SERFF Tracking Number:	*AENX-125694181*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*39294*
Company Tracking Number:	*GH AR0033301F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2008 Business Alliance*		
Project Name/Number:	*2008 Business Alliance/GH AR0033301F01*		

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2008 Business Alliance	SERFF Tr Num: AENX-125694181	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 39294
Sub-TOI: H21.000 Health - Other	Co Tr Num: GH AR0033301F01	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: SPI AetnaSPI	Disposition Date: 06/13/2008
	Date Submitted: 06/12/2008	Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 2008 Business Alliance	Status of Filing in Domicile:
Project Number: GH AR0033301F01	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 06/13/2008	
State Status Changed: 06/13/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

The purpose of this submission is to expand benefit ranges and add new benefit features to our medical plans in order to enhance plan design flexibility for our policyholders.

In addition:

In response to a given policyholder's needs, a plan may be written as an accident only medical plan. The terms "illness" and/or "disease" will be deleted accordingly from the plan documents if a policyholder's plan is an accident only medical plan.

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In response to a given policyholder's needs, a plan may be written as an outpatient only medical plan. References to inpatient facility expenses will be deleted accordingly from the plan documents if a policyholder's plan is an outpatient only medical plan. Outpatient only medical plans will be offered in conjunction with a hospital (or hospital/inpatient facility) confinement indemnity plan to policyholders.
The hospital (or hospital/inpatient facility) confinement indemnity plans may be network based.

Company and Contact

Filing Contact Information

John Ciesielski, Product and Regulatory Affairs Manager	CiesielskiJW@Aetna.com
151 Farmington Avenue	(860) 279-1282 [Phone]
Hartford, CT 06156	(860) 952-2069[FAX]

Filing Company Information

Aetna Life Insurance Company	CoCode: 60054	State of Domicile: Connecticut
151 Farmington Avenue	Group Code: 1	Company Type:
Hartford, CT 06156	Group Name: Aetna	State ID Number:
(860) 273-7546 ext. [Phone]	FEIN Number: 06-6033492	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	$50.00	06/12/2008	20823302

SERFF Tracking Number:	*AENX-125694181*	*State:*	*Arkansas*
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Product Name:	*2008 Business Alliance*		
Project Name/Number:	*2008 Business Alliance/GH AR0033301F01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/13/2008	06/13/2008

SERFF Tracking Number:	*AENX-125694181*	*State:*	*Arkansas*
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Product Name:	*2008 Business Alliance*		
Project Name/Number:	*2008 Business Alliance/GH AR0033301F01*		

Disposition

Disposition Date: 06/13/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AENX-125694181*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*39294*
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Product Name:	*2008 Business Alliance*		
Project Name/Number:	*2008 Business Alliance/GH AR0033301F01*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Certification/Notice	Approved-Closed	Yes
Form	What The Plan Covers	Approved-Closed	Yes
Form	Physician Services	Approved-Closed	Yes
Form	Exclusions	Approved-Closed	Yes
Form	Calendar Year Deductibles	Approved-Closed	Yes
Form	[Calendar Year] [Monthly] Maximum Benefits	Approved-Closed	Yes
Form	Treatment of Injuries Relating To An Accident	Approved-Closed	Yes
Form	Routine Preventative Care Expenses	Approved-Closed	Yes
Form	Physician Expenses	Approved-Closed	Yes
Form	Hospital Expenses/Facility Expenses	Approved-Closed	Yes
Form	Coverage for Emergency Medical Conditions	Approved-Closed	Yes
Form	Alternatives to Hospital Stays	Approved-Closed	Yes
Form	Other Covered Health Care Expenses	Approved-Closed	Yes
Form	Specialized Care	Approved-Closed	Yes
Form	Treatment of Alcoholism, Drug Abuse	Approved-Closed	Yes
Form	Oral and Maxillofacial Treatment	Approved-Closed	Yes
Form	Supplemental Expense Benefits	Approved-Closed	Yes
Form	Calendar Year Deductibles	Approved-Closed	Yes
Form	Calendar Year and Monthly Maximum Benefits	Approved-Closed	Yes
Form	Lifetime Maximum Benefits	Approved-Closed	Yes
Form	Treatment of Injuries Relating To An Accident Benefit	Approved-Closed	Yes
Form	Routine Preventative Care Expenses	Approved-Closed	Yes
Form	Physician Expenses	Approved-Closed	Yes
Form	Hospital Expenses/Facility Expenses	Approved-Closed	Yes
	Coverage for Emergency Medical	Approved-Closed	Yes

SERFF Tracking Number:	*AENX-125694181*	*State:*	*Arkansas*
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Form	Conditions		
Form	Alternatives to Hospital Stays	Approved-Closed	Yes
Form	Other Covered Health Care Expenses	Approved-Closed	Yes
Form	Specialized Care	Approved-Closed	Yes
Form	Treatment of Alcoholism, Drug Abuse	Approved-Closed	Yes
Form	Oral and Maxillofacila Treatment	Approved-Closed	Yes
Form	Supplemental Expense Benefits	Approved-Closed	Yes
Form	When Coverage Ends for Employees	Approved-Closed	Yes
Form	When Coverage Ends for Dependents	Approved-Closed	Yes
Form	Premium Contribution Provisions	Approved-Closed	Yes
Form	Facility Indemnity Plan (Without Ranges)	Approved-Closed	Yes
Form	Facility Indemnity Plan (With Ranges)	Approved-Closed	Yes
Form	Glossary	Approved-Closed	Yes
Form	Premium Contribution Provisions (Without Ranges)	Approved-Closed	Yes
Form	Premium Contribution Provisions (With Ranges)	Approved-Closed	Yes

SERFF Tracking Number:	*AENX-125694181*	*State:*	*Arkansas*
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Form Schedule

Lead Form Number: GR-9N 14-005 02

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GR-9N 14-005 02	Certificate Amendment, Insert Page, Endorsement or Rider	What The Plan Covers	Initial		36	GR-9N 14-005 02.PDF
Approved-Closed	GR-9N 14-025 03	Certificate Amendment, Insert Page, Endorsement or Rider	Physician Services	Initial		33	GR-9N 14-025 03.PDF
Approved-Closed	GR-9N 28-015 05	Certificate Amendment, Insert Page, Endorsement or Rider	Exclusions	Initial		28	GR-9N 28-015 05.PDF
Approved-Closed	GR-9N S-14-05 03	Schedule Pages	Calendar Year Deductibles	Initial		0	GR-9N S-14-05 03.PDF
Approved-Closed	GR-9N S-14-10 03	Schedule Pages	[Calendar Year] [Monthly] Maximum Benefits	Initial		0	GR-9N S-14-10 03.PDF
Approved-Closed	GR-9N S-14-20 03	Schedule Pages	Treatment of Injuries Relating To An Accident	Initial		0	GR-9N S-14-20 03.PDF
Approved-Closed	GR-9N S-14-25 03	Schedule Pages	Routine Preventative Care Expenses	Initial		0	GR-9N S-14-25 03.PDF
Approved-Closed	GR-9N S-14-30 03	Schedule Pages	Physician Expenses	Initial		0	GR-9N S-14-30 03.PDF
Approved-Closed	GR-9N S-14-35 03	Schedule Pages	Hospital Expenses/Facility	Initial		0	GR-9N S-14-35 03.PDF

			Expenses			
Approved-Closed	GR-9N S-14-40 03	Schedule Pages	Coverage for Emergency Medical Conditions	Initial	0	GR-9N S-14-40 03.PDF
Approved-Closed	GR-9N S-14-45 03	Schedule Pages	Alternatives to Hospital Stays	Initial	0	GR-9N S-14-45 03.PDF
Approved-Closed	GR-9N S-14-50 03	Schedule Pages	Other Covered Health Care Expenses	Initial	0	GR-9N S-14-50 03.PDF
Approved-Closed	GR-9N S-14-55 03	Schedule Pages	Specialized Care	Initial	0	GR-9N S-14-55 03.PDF
Approved-Closed	GR-9N S-14-60 03	Schedule Pages	Treatment of Alcoholism, Drug Abuse	Initial	0	GR-9N S-14-60 03.PDF
Approved-Closed	GR-9N S-14-65 03	Schedule Pages	Oral and Maxillofacial Treatment	Initial	0	GR-9N S-14-65 03.PDF
Approved-Closed	GR-9N S-14-70 03	Schedule Pages	Supplemental Expense Benefits	Initial	0	GR-9N S-14-70 03.PDF
Approved-Closed	GR-9N S-15-05 03	Schedule Pages	Calendar Year Deductibles	Initial	0	GR-9N S-15-05 03.PDF
Approved-Closed	GR-9N S-15-10 03	Schedule Pages	Calendar Year and Monthly Maximum Benefits	Initial	0	GR-9N S-15-10 03.PDF
Approved-Closed	GR-9N S-15-15 03	Schedule Pages	Lifetime Maximum Benefits	Initial	0	GR-9N S-15-15 03.PDF
Approved-Closed	GR-9N S-15-20 03	Schedule Pages	Treatment of Injuries Relating To An Accident Benefit	Initial	0	GR-9N S-15-20 03.PDF
Approved-Closed	GR-9N S-15-25 03	Schedule Pages	Routine Preventative Care Expenses	Initial	0	GR-9N S-15-25 03.PDF
Approved-Closed	GR-9N S-15-30 03	Schedule Pages	Physician Expenses	Initial	0	GR-9N S-15-30 03.PDF
Approved-Closed	GR-9N S-15-35 03	Schedule Pages	Hospital Expenses/Facility Expenses	Initial	0	GR-9N S-15-35 03.PDF
Approved-Closed	GR-9N S-15-40 03	Schedule Pages	Coverage for Emergency Medical Conditions	Initial	0	GR-9N S-15-40 03.PDF

SERFF Tracking Number:	*AENX-125694181*			*State:*	*Arkansas*		
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Product Name:	*2008 Business Alliance*						
Project Name/Number:	*2008 Business Alliance/GH AR0033301F01*						

Approved-Closed	GR-9N S-15-45 03	Schedule Pages	Alternatives to Hospital Stays	Initial		0	GR-9N S-15-45 03.PDF
Approved-Closed	GR-9N S-15-50 03	Schedule Pages	Other Covered Health Care Expenses	Initial		0	GR-9N S-15-50 03.PDF
Approved-Closed	GR-9N S-15-55 03	Schedule Pages	Specialized Care	Initial		0	GR-9N S-15-55 03.PDF
Approved-Closed	GR-9N S-15-60 03	Schedule Pages	Treatment of Alcoholism, Drug Abuse	Initial		0	GR-9N S-15-60 03.PDF
Approved-Closed	GR-9N S-15-65 03	Schedule Pages	Oral and Maxillofacial Treatment	Initial		0	GR-9N S-15-65 03.PDF
Approved-Closed	GR-9N S-15-70 03	Schedule Pages	Supplemental Expense Benefits	Initial		0	GR-9N S-15-70 03.PDF
Approved-Closed	GR-9N 30-005 03	Certificate Amendment, Insert Page, Endorsement or Rider	When Coverage Ends for Employees	Initial		45	GR-9N 30-005 03.PDF
Approved-Closed	GR-9N 30-015 04	Certificate Amendment, Insert Page, Endorsement or Rider	When Coverage Ends for Dependents	Initial		38	GR-9N 30-015 04.PDF
Approved-Closed	GR-9N 30-020 01	Certificate Amendment, Insert Page, Endorsement or Rider	Premium Contribution Provisions	Initial		37	GR-9N 30-020 01.PDF
Approved-Closed	GR-96173 50-1b	Certificate Amendment, Insert Page, Endorsement or Rider	Facility Indemnity Plan (Without Ranges)	Initial		41	GR-96173 50-1b.PDF

SERFF Tracking Number:	*AENX-125694181*			*State:*	*Arkansas*		
Filing Company:	*Aetna Life Insurance Company*			*State Tracking Number:*	*39294*		
Company Tracking Number:	*GH AR0033301F01*						
TOI:	*H21 Health - Other*			*Sub-TOI:*	*H21.000 Health - Other*		
Product Name:	*2008 Business Alliance*						
Project Name/Number:	*2008 Business Alliance/GH AR0033301F01*						

Approved-Closed	GR-96173 50-1b	Certificate Amendment, Insert Page, Endorsement or Rider	Facility Indemnity Plan (With Ranges)	Initial		41	GR-96173 50-1b.PDF
Approved-Closed	GR-96173 80-5d	Certificate Amendment, Insert Page, Endorsement or Rider	Glossary	Initial		47	GR-96173 80-5d.PDF
Approved-Closed	GR-96173 90	Certificate Amendment, Insert Page, Endorsement or Rider	Premium Contribution Provisions (Without Ranges)	Initial		41	GR-96173 90.PDF
Approved-Closed	GR-96173 90	Certificate Amendment, Insert Page, Endorsement or Rider	Premium Contribution Provisions (With Ranges)	Initial		41	GR-96173 90.PDF

[WHAT THE PLAN COVERS]
[Limited] [Major] [Comprehensive] [PPO] [Outpatient Only] [Accident Only] [Medical] Expense Insurance

[Please read these materials carefully as the plan of benefits described in this Booklet-Certificate is limited to outpatient expenses]. [Please read these materials carefully as the plan of benefits described in this Booklet-Certificate is limited to **accident** expenses].

Many [preventive and] routine [medical] expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

[Treatment Of Injuries Relating To An Accident Expense Benefit

Inpatient Treatment
This Plan pays the charges of a **hospital** [**rehabilitation facility, convalescent facility**, **and skilled nursing facility**] for **room and board** while confined for the treatment of **injuries** relating to an **accident**. **Room and board** charges include all charges for services made in connection with room occupancy. This means things such as general nursing care.

Additional Inpatient Benefits
While **room and board** benefits are paid, this Plan also pays a benefit for charges made by a **physician** or the facility for other services and supplies while a covered person is confined as an inpatient. This does not include those made for **room and board** or for private duty nursing or special nursing services.

Outpatient Treatment
Covered expenses include charges incurred on an outpatient basis for the treatment of **injuries** relating to an **accident**.]

[Calendar Year Maximum For Treatment Of Injuries Relating to An Accident
This is the most this Plan will pay for covered inpatient and outpatient expenses incurred by a covered person per calendar year for the treatment of **injuries** relating to an **accident** under the Treatment for Injuries Relating to An Accident Expense Benefit.]

[Important Reminder

Refer to the *Summary of Benefits* for details about **deductibles, coinsurance** and maximum benefit limits.]

[Physician Services

Physician Visits

Covered expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician's** office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Charges made by the **physician** for supplies, x-rays, and tests provided by the **physician**.
- Non-surgical medical treatment given to a covered person while confined as an inpatient in a **hospital** treatment facility, **rehabilitation facility, convalescent facility, skilled nursing facility, or hospice facility** and for consultation services given to a covered person while confined as an inpatient in such facility. Consultation services must be asked for by the attending **physician.**

  A "consultation" is an exam of the covered person, a review of his or her x-ray and lab exams, and a review of the covered person's medical history. It will include a written report by the consulting **physician** if the attending **physician** requests one.

  No benefits are paid for consultation services:

  - If the consulting **physician** performs surgery as a result of the consultation.

  - For staff consultations required by a facility.

Surgery

Covered expenses include charges made by a **physician** for:

- Performing your surgical procedure; and
- Pre-operative and post-operative visits.

Also covered are Surgical Assistance Services. These are the services of a **physician** in giving needed technical assistance to the operating **physician** during a Surgical Service for which a benefit is paid under this Plan. No benefit is paid if such assistance is routinely done as a service by an intern; a resident **physician**; or a house officer; of a **hospital.**

[Surgical Services Calendar Year Maximum

This is the most this Plan will pay for all covered surgical expenses incurred by a covered person in a calendar year under the Physician Expenses benefit.]

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a **physician,** other than the operating **physician,** or registered nurse anesthetist (R.N.A) in connection with a covered procedure.]

[Anesthesia Services Calendar Year Maximum

This is the most this Plan will pay for all covered anesthesia expenses incurred by a covered person in a [calendar year] under the Physician Expenses benefit.]

[Important Reminder

Refer to the *Schedule of Benefits* for details about **copays, deductibles, coinsurance** and maximum benefit limits.]

[Alternatives to Physician Office Visits]

[Walk-In Clinic Visits

Covered expenses include charges made by **network walk-in clinics** for unscheduled, non-emergency **illnesses** and **injuries**; and the administration of certain immunizations administered within the scope of the clinic's license.]

[E-Visits

Covered expenses include charges made by your**network physician**, **primary care physician**, (**PCP**)] for a routine, non-emergency, medical consultation. You must make your **E-visit** through an **Aetna** authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on www.Aetna.com or by calling the number on your identification card.]

Exclusions That Apply to [Basic] [Limited] [Major] [Comprehensive] [PPO] [POS] [EPO] Medical Insurance

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are [**medically necessary]** [and] included in the [*What the Plan Covers*] section. Charges made for the following are not covered except to the extent listed under the [*What the Plan Covers*] section or by amendment attached to this Booklet-Certificate.

[**Important Note**:

You have medical and **prescription drug**; dental; vision; hearing, insurance coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific **prescription drug**, dental, vision and hearing coverage. Those additional exclusions are listed separately at the end of this section, if applicable.]

[Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.]

[Allergy*:* Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.]

[Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet-Certificate.]

[Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, **prescription drugs**, or supplies, even if otherwise covered under this Booklet-Certificate, or such drugs or supplies are unavailable or illegal in the United States, or the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.]

[Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.]

[Artificial organs: Any device intended to perform the function of a body organ.]

Behavioral Health Services:

- [Alcoholism or drug abuse **Substance Abuse**] rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for **detoxification** or treatment of alcoholism and drug abuse is specifically provided in the *What the Plan Covers* Section].
- [Non-serious; Non biologically based and Serious; Biologically based Mental health services, inpatient and outpatient;]
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- [Treatment in wilderness programs or other similar programs.]

[Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retardation in accordance with the benefits provided in the *What the Plan Covers* section of this Booklet-Certificate.]

[Blood, blood plasma, synthetic blood, blood derivatives or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.]

[Charges for a service or supply furnished by a **network** or **out-of-network provider** in excess of the **negotiated charge**.]

[Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.]

[Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.]

[Contraception except as specifically described in the *What the Plan Covers* section]:

- [Over the counter contraceptive supplies including but not limited to: condoms, contraceptive foams, jellies and ointments.][;]
- [any drug, or supply to prevent or terminate pregnancy, including: birth control pills, patches and implantable contraceptive drugs];
- [contraceptive devices such as: inter-uterine devices (IUDs) and diaphragms, including initial fitting and insertion], [even if for a medical condition other than birth control];
- [Tubal ligation, vasectomy and other forms of voluntary sterilization], [including associated services and supplies including related follow-up care [and treatment of complications of such procedures;]]; and
- [Services associated with the prescribing, monitoring and/or administration of contraceptives].]

Cosmetic services and plastic surgery**:** any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons except as specifically described under [*Reconstructive Services* and *Specialized Care*] sections of the [*What the Plan Covers*] section including:

- [Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin; and
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy);
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation;
- Otoplasty.]

[Costs for services resulting from the commission of, or attempt to commit a felony by the covered person.]

[Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.]

[Court ordered services, including those required as a condition of parole or release.]

Custodial care.

[Dental Services: except as specifically described in the *What the Plan Covers* section any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of **injuries** and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- Services of **dentists**, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, [soft tissue impactions,] [removal of bony impacted teeth,] treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth;
- [Non-surgical][surgical] treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment;

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.]

[Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.]

[Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any **prescription drug** purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to travel or work;
- [Needles, syringes and other injectable aids , except as covered for diabetic supplies;]
- Drugs related to the treatment of non-covered expenses;
- Performance enhancing steroids;
- [Implantable drugs and associated devices;]
- [Injectable drugs if an alternative oral drug is available;]
- [Outpatient **prescription drugs**;]
- [Self- injectable **prescription drugs** and medications;]
- [Any **prescription drugs**, injectibles, or medications or supplies provided by the policyholder or through a third party vendor contract with the policyholder].
- [Any expenses for prescription drugs, and supplies covered under an **Aetna** Managed Prescription Plan will not be covered under this medical expense plan; **Prescription drug** exclusions that apply to the **Aetna** managed prescription plan will apply to the medical expense coverage;]
- [Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.]

[**Durable medical and surgical equipment** including purchase, rental, replacement or repair, from an **out-of-network provider**, except as specifically provided in the *What the Plan Covers* section.]

[Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.]

[Examinations:

Any health examinations:

- required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
- required by any law of a government, securing insurance or school admissions, or professional or other licenses;
- required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
- any special medical reports not directly related to treatment except when provided as part of a covered service.]

[Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.]

[**Experimental or investigational** drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.]

Facility charges for care, services or supplies provided in:

- [rest homes;
- assisted living facilities;
- similar institutions serving as an individuals primary residence or providing primarily custodial or rest care;
- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps].

[Food and nutritional items: Any food item, including infant formulas, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.]

[Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including:

- treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes (including orthopedic shoes), orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.]

[Genetics: Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.]

[Growth/Height: Any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones.]

[Hearing:

- [Any hearing service or supply that does not meet professionally accepted standards;]
- Hearing exams given during a **stay** in a **hospital** or other facility;
- [Any tests, appliances, and devices for the improvement of hearing, including aids, hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech;]
- [Routine hearing exams, except as covered under well child services].

[Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, including:

- Bathroom equipment such as bathtub seats, benches, rails, and lifts;
- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, massage devices or over-bed tables;
- Equipment or supplies to aid sleeping or sitting, including electric beds, water beds, air beds, pillows, sheets, blankets, warming or cooling devices, elevating chairs, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**; and
- transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.]

[Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.]

[Home uterine activity monitoring.]

Infertility: [except as specifically described in the *What the Plan Covers* section,] any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- [drugs, and drugs related to the treatment of non-covered benefits;]
- [Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;]
- [Artificial insemination;]
- [Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); artificial insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;]
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests;
- [Any charges associated with care required to obtain ART Services (e.g., office, **hospital**, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures;
- ovulation induction and intrauterine insemination services if you are not fertile].

[**Maintenance care]**

[Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.]

[Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a **physician**'s practice;
- Charges to have preferred access to a **physician**'s services such as boutique or concierge **physician** practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public **hospital** or other facility is required to provide; or
  - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.]

Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

[Treatment of conditions not related to an **accident**.]

Non-[**medically necessary**] services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not [**medically necessary]**, as determined by **Aetn**a, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist.**

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

[Pregnancy Charges: Charges in connection with pregnancy care , other than for pregnancy complications. Pregnancy complications means:

- Hyperemesis gravidarum (pernicious vomiting of pregnancy); toxemia with convulsions; severe bleeding before delivery due to premature separation of the placenta from any cause; bleeding after delivery severe enough to need a transfusion or blood; or
- Amniotic fluid tests, analyses, or intra-uterine fetal transfusion made for Rh incompatibility; or
- A non-emergency cesarean delivery; a surgical procedure for pregnancy outside the womb; cutting through the wall of the abdomen at the end of, but on account of, pregnancy; or
- Miscarriage if not elective or therapeutic.]

[Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services. Skilled Nursing Care is covered as specifically described in the *What the Plan Covers* section in accordance with a home health treatment plan approved by **Aetna**.]

[Prosthetics or prosthetic devices unless specifically covered under *What the Plan Covers* section.]

Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling.

Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

[Services of a resident **physician** or intern rendered in that capacity.]

[Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.]

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

[Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.]

Services, [including those related to pregnancy,] rendered before the effective date or after the termination of coverage, unless coverage is continued under the [*Continuation of Coverage*] section of this Booklet-Certificate.

Services that are not covered under this Booklet-Certificate [, even when a prior referral has been issued by a **PCP]**.

[Services and supplies provided on an inpatient basis.]

[Services and supplies provided in connection with treatment or care that is not covered under the plan.]

[Services and supplies provided by an **out-of-network provider**.]

[Speech therapy for treatment of delays in speech development, except as specifically provided in the *What the Plan Covers* section. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.]

[Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What the Plan Covers* section.]

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat **illnesses**, **injuries** or disabilities related to the use of performance-enhancing drugs or preparations.

Therapies for the treatment of delays in development, unless resulting from acute **illness** or **injury**, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Therapies and tests**:** Any of the following treatments or procedures:

- [Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Full body CT scans;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a **network physician** as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.]

[Transplant-The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants unless otherwise **precertified** by **Aetna**;
- services and supplies not obtained from an **IOE** including the harvesting of organs, bone marrow, tissue or stem cells for storage purposes.]

Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services except as described in the [*What the Plan Covers*] section.

[Unauthorized services, including any service obtained by or on behalf of your or your covered dependent without a **Referral** issued by the **PCP** when required or **Precertification** by **Aetna** when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.]

[Vision-related services and supplies,except as described in the *What the Plan Covers* section, the plan does not cover:

- Anti-reflective coatings;
- Special supplies such as non-**prescription** sunglasses and subnormal vision aids;
- Vision services or supplies which do not meet professionally accepted standards;
- Tinting of eyeglass lenses;
- Special vision procedures, such as orthoptics, vision therapy or vision training;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams to diagnose or treat a illness or **injury**;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.]

[Voluntary termination of pregnancy, including related services.]

[Weight: Any treatment, drug, service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions;except as provided by this Booklet-Certificate, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.]

[Work related: Any **illness** or **injury** related to employment or self-employment including any **injuries** that arise out of (or in the course of) any work for pay or profit unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an **occupational illness** or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source.If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "**non-occupational**" regardless of cause.]

Regulator Note - In addition to the General Exclusion items listed on the previous pages, the following exclusions apply to the [Limited] [Comprehensive] [Major] Medical Plans:

Behavioral Health Services:

- [Alcoholism or drug abuse] [**Substance Abuse**] services and supplies, inpatient and outpatient; and
- Mental health services and supplies, inpatient and outpatient.

Non-surgical medical treatment provided by a **physician** to a covered person while confined as an inpatient in a **hospital,** [**residential, treatment facility, rehabilitation facility, convalescent facility, skilled nursing facility, or hospice facility]**. This includes consultation services given to a covered person while confined as an inpatient in such facility. A "consultation" is an exam of the covered person; a review of his or her x-ray and lab exams; a review of the covered person's medical history; and a written report by the consulting **physician** if the attending **physician** requests one.

Except for benefits that must be provided for by law and as otherwise provided for in your Booklet- Certificate, all outpatient services and supplies that are not deemed to be:

- **physician** office visits;
- emergency room visits[;
- diagnostic and surgical services; or
- **prescription drugs** and medicines].

Such outpatient services and supplies that are excluded under the policy include, but are not limited to: [physical therapy; occupational therapy; speech therapy; spinal manipulation; durable medical equipment; prosthesis; home health care; and hospice care].

Prescription drugs and medicines prescribed by a **physician** while you are confined as an inpatient.

Services and supplies provided in connection with the treatment of an **injury** sustained while the covered person was legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the **injury** occurred.

Services and supplies provided in connection with the treatment of an **injury** sustained while the covered person was voluntarily using any drug, narcotic or controlled substance unless as prescribed by a **physician**.

Services and supplies provided in connection with the treatment of an **illness** or **injury** sustained while flying as a pilot or crew member of any aircraft or travel or flight. This includes boarding or alighting in any vehicle or device while being used for any test or experimental purposes or while being operated by, for, or under the direction of any military authority other than the Military Airlift Command of the United States or similar air transport service of any other country.

Services and supplies provided by a **hospita**l or treatment facility owned or run by the U.S. government unless a charge is made for such services in the absence of insurance.

Services and supplies provided by a **hospital** which does not unconditionally require payment (this does not apply to charges billed by Veterans Administration Hospitals).

Services and supplies incurred during any phase of a process relating to replacement of solid organs, stem cells, bone marrow or tissue.

Services and supplies provided to treat an **injury** caused by, or resulting from, participation in any riot, civil commotion or service in the Armed Forces of any country.

[Policyholder: ABC Company
Group Policy Number: 12345
Effective Date: January 1, 2004]

Aetna Life Insurance Company
[Limited] [Major] [Comprehensive][Outpatient Only] [Accident Only] Medical Expense Coverage
[Schedule of Benefits]

PLAN FEATURES

Please read these materials carefully as the plan of benefits described in this Booklet-Certificate is limited [to outpatient expenses] [to **accident** expenses] and contains a number of specific limits on visits, services and dollar amounts, in addition to overall dollar maximum benefits payable under the policy. Once these limits have been reached, the plan will not pay any more towards the cost of the services in question and you will be responsible for the remaining unpaid charges or expenses.

This Booklet-Certificate explains these visit and service limits, the overall annual benefit maximum, and other cost sharing features of your plan, such as copayments and deductibles.

Calendar Year Deductibles

[Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.]

[Calendar Year **Deductible]**	[$0-$600]
*[Family **Deductible** Limit]*	[$0-$1,800]

[Inpatient Calendar Year **Deductible**]	[$0-$500]
*[Family **Deductible** Limit]*	[$0-$1,500]
[**Covered expenses** incurred as a result of an **accident** and applied to this **deductible** apply to satisfy the Accident Calendar Year **Deductible**.]	

[Outpatient Calendar Year **Deductible]**	[$0-$400]
*[Family **Deductible** Limit]*	[$0-$1,200]

[Hospital Emergency Room Calendar Year **Deductible]**	[$0-$500]

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[**Accident** Calendar Year **Deductible]**	[$0-$250]
[**Covered expenses** incurred as a result of an **accident** and applied to the Inpatient Calendar Year **Deductible** apply to satisfy this **deductible**.]	

[Policyholder: ABC Company
Group Policy Number: 12345
Effective Date: January 1, 2004]

[Schedule of Benefits]

[Calendar Year] [Monthly] Maximum Benefits

[Calendar Year Maximum Benefit]	[$1,000-$150,000*]
[The most the plan will pay for **covered expenses** incurred by any one covered person in a calendar year is called the Calendar Year Maximum Benefit.]	

[*$500-$15,000 of this maximum is reserved for outpatient expenses]

[Supplemental Calendar Year Maximum Benefit	[$1,000-$45,000]
If a covered person has exhausted their Calendar Year Maximum Benefit, an additional benefit may be paid for **covered expenses** incurred by any one covered person in a calendar year.]	

[Inpatient Calendar Year Maximum Benefit]	[$500-$50,000]

[The most the plan will pay for **covered expenses** incurred by any one covered person in a calendar year for charges for **room and board** and other services or supplies given to the person during a **stay** in a **hospital** or other facility is called the Inpatient Calendar Year Maximum Benefit. The inpatient Calendar Year Maximum Benefit is reduced by benefits paid and applied toward the Physician Expenses, Hospital Expenses, and Facility Expenses maximums. Refer to Physician Expenses, Hospital Expenses, and Facility Expenses benefits in this *Schedule of Benefits* for applicable maximum amounts.]

[If a covered person has exhausted this maximum in a calendar year, an additional benefit may be paid in that calendar year if the person has a **stay** in a **hospital** or other facility. The additional benefit is the Inpatient Supplemental Medical Benefit.]

[Outpatient Calendar Year Maximum Benefit]	[$200-$15,000]

[The most the plan will pay for **covered expenses** incurred by any one covered person in a calendar year for charges for services or supplies given to the person while *not* confined as a full-time inpatient is called the Outpatient Calendar Year Maximum Benefit.]

[Outpatient Calendar Year Maximum Visits]	[2-10]

[The calendar year maximum benefits do not apply to the "[basic] [and] [limited] [major] [special] [comprehensive] [medical] [dental] [vision] [hearing] [**prescription drug**] expense coverage" described in the Booklet-Certificate.]

As indicated below, the calendar year maximum benefits will not deny benefits for certain **covered expenses** in any one calendar year.

[Outpatient Prescription Drug Calendar Year Maximum Benefit	$150-$3,000

The most the plan will pay for outpatient prescription drug expenses incurred by any one covered person in a calendar year is called the Outpatient Prescription Drug Calendar Year Maximum Benefit. Covered **prescription drug** expenses [will] [will not] be applied toward the Outpatient Calendar Year Maximum Benefit.]

[Schedule of Benefits]

[Outpatient Prescription Drug Monthly Maximum Benefit	$35-$200

The most the plan will pay for outpatient **prescription drug** expenses incurred by any one covered person in a month is called the Outpatient Prescription Drug Calendar Year Maximum Benefit. Covered **prescription drug** expenses [will] [will not] be applied toward the Outpatient Calendar Year Maximum Benefit.]

[Policyholder: ABC Company
Group Policy Number: 12345
Effective Date: January 1, 2004]

[Schedule of Benefits]

[The **coinsurance** listed in the *Schedule of Benefits* below reflects the Plan Coinsurance. This is the amount **Aetna** pays. You are responsible to pay any **deductibles** and remaining **coinsurance** percentage. You are responsible for full payment of any non-covered expenses you incur.]

[ALL COVERED EXPENSES ARE SUBJECT TO ANY APPLICABLE CALENDAR YEAR DEDUCTIBLE UNLESS OTHERWISE NOTED IN THE *SUMMARY OF BENEFITS* BELOW.]

PLAN FEATURES	
[Treatment of Injuries Related to an Accident Expense Benefit]	
[Inpatient Treatment]	[50%-100% after the $0-$50 **deductible** per **occurrence**, and Calendar Year **Deductible,** and Inpatient Calendar Year **Deductible**, and the Accident Calendar Year **Deductible**, and a $0-$50 per admission **deductible**]
[Additional Inpatient Benefits]	[50%-100% after the $0-$50 **deductible** per **occurrence**, and Calendar Year **Deductible,** and Inpatient Calendar Year **Deductible** and Accident Calendar Year **Deductible]**
[Daily maximum benefit for **room and board**]	[$250-$2,000 per day, up to 20-30 days per calendar year]
[Outpatient Treatment]	[50%-100% after the $0-$50 **deductible** per **occurrence**, and Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible**, and Accident Calendar Year **Deductible]**
[Maximum per calendar year for *inpatient & outpatient treatment*]	[$300-$15,000*]
	[*This maximum does not apply to **room and board** expenses.]
[Maximum **occurrences** per calendar year for *inpatient & outpatient treatment*]	[1-5]
[Maximum benefit per **occurrence** for *inpatient & outpatient] treatment*]	[$300-$10,000]
[Treatment of Non-Accident Related Conditions Expense Benefit]	
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible**, and a $0-$50 per admission **deductible**]
[Daily maximum benefit for **room and board]**	[$250-$2,000 per day, up to 20-30 days per calendar year]

[Schedule of Benefits]

[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]
[Maximum number of emergency room visits per calendar year]	[3-6]
[Maximum benefit per emergency room visit]	[$50-$100]
[Maximum **physician** office visits per calendar year]	[6-10*]
[*One office visit may be used for a routine physical or gynecological exam after a covered person has completed 1-6 months of constant coverage under the Plan.]	
[Maximum per **physician** office visit]	[$50-$100]
[Diagnostic Services:]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]
[Maximum number of services per calendar year]	[5-15]
[Maximum per service]	[$50-$100]

[Schedule of Benefits]

PLAN FEATURES	
[Routine Preventive Care Expenses Adults & Children]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible**, and a $0-$50 office visit **deductible**]
[Maximum per calendar year]	[$100-$200]
[Family Planning Services]	
[Voluntary Sterilization (including tubal ligation and vasectomy)]	
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible**, and a $0-$50 per procedure **deductible**]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**, and a $0-$50 per procedure **deductible**]
[Maximum per [calendar year] [lifetime] for *inpatient and outpatient treatment]*	[$100-$400]

[Schedule of Benefits]

PLAN FEATURES	
[Physician Expenses]	
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**]
[Maximum per calendar year for surgical services]	[$100-$4,000]
[Maximum per surgery for surgical assistance services]	[Not more than 25%-50% of the operating physician's charges.]
[Maximum per calendar year for anesthesia services]	[$100-$4,000]
[Maximum per physician visit to facility where you are confined]	[$35-$100]
[Outpatient Treatment (Non-Surgical Office Visit)]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum number of non-surgical office visits per calendar year]	[5-10]
[Maximum per non-surgical office visit]	[$35-$100]
[Outpatient Treatment (Surgical Office Visit)]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum number of surgical office visits per calendar year]	[5-10]
[Maximum per surgical office visit]	[$35-$100]
[Diagnostic Laboratory and X-ray Expenses Performed in a Physician's Office except for Complex Imaging Services - (If performed as a part of a **physician's** office visit and billed by the **physician**; coverage of expenses is the same as a **physicians** office visit.)]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum per calendar year]	[$25-$400] [1-5 procedures]

[Schedule of Benefits]

PLAN FEATURES	
[Alternatives to Physician Office Visits]	
*[**E-visit** Online Consultation by a **PCP**]*	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 per visit **deductible**]
*[**Walk-In Clinic** Non-Emergency Visit Includes coverage for immunizations.]*	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 per visit **deductible**]
[Maximum number of visits per calendar year]	[2-15]
[Maximum benefit per calendar year]	[$50-$500]

[Schedule of Benefits]

PLAN FEATURES	
[Hospital Expenses]	
[Inpatient Hospital Expenses] (including maternity)	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]
[Maximum per day]	[$200-$600]
[Outpatient Hospital Expenses (including surgery):]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit/surgical procedure]
[Maximum per visit]	[$50-$200]
[Maximum per [calendar year] [lifetime]]	[$2,500-$8,000] [3-10 visits]
[Maximum per calendar year (applies to *inpatient and outpatient hospital expenses*)]	[$2,000-6,000*]
[*This maximum does not apply to **room and board** expenses.]	
[Facility Expenses]	
[Inpatient Facility Expenses]	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]
[Daily maximum benefit for **room and board**]	[$200-$600]
[ICU maximum per day]	[$300-$500]
[Maximum per calendar year for other facility services and supplies]	[$500-$3,500]
[Maximum days per period of confinement]	[15-30]
[Daily maximum benefit]	[$300-$600 per day up to 5-10 days per period of confinement]
[Outpatient Facility Expenses]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]

[Policyholder: ABC Company
Group Policy Number: 12345
Effective Date: January 1, 2004]

[Schedule of Benefits]

PLAN FEATURES	
[**Coverage For Emergency Medical Conditions**]	
[Emergency Room]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible**, and **Hospital** Emergency Room Calendar Year **Deductible**, and a $0-$100 **deductible** per emergency room visit]
[Maximum number of visits per calendar year]	[3-6]
[Maximum per visit]	[$35-$150]
[Maximum per calendar year]	[$500-$5,000]
Non-Emergency Care in a Hospital Emergency Room	Not Covered

[If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your emergency room per visit **deductible** is waived.]

[**Covered expenses** that are applied to the **Hospital** Emergency Room Calendar Year **Deductible** or emergency room per visit **deductible** cannot be applied to any other **deductibles** under your plan. Likewise, **covered expenses** that are applied to any of your plan's other **deductibles** cannot be applied to the Emergency Room Calendar Year **Deductible** or emergency room per visit **deductible.**]

[Schedule of Benefits]

[ALTERNATIVES TO HOSPITAL STAYS]	
PLAN FEATURES	
[Outpatient Surgery and Physician's Services]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per surgery] [Not covered.]
[Outpatient Diagnostic and Surgical Services Expenses]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per service]
[Maximum number of services per calendar year]	[5-15]
[Maximum per calendar year]	[$200-$2,000]
[Maximum per calendar year]	[The first to occur of 5-15 visits or $200-$2,000]
[Birthing Center and Physicians Services]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per birth] [Not covered.]
[**Home Health Care]**	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible**] [Not covered.]
[Maximum number of visits per calendar year]	[15-60 visits]
[Maximum number of visits per lifetime]	[60-120]
[Maximum number of visits per day]	[1-4]
[Skilled Nursing Facility]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[Maximum per day]	[$200-$600]
[Maximum per [calendar year] [lifetime]]	[15-45 days] [$15,000-$45,000] [3-9 admissions]

[Schedule of Benefits]

PLAN FEATURES	
[Private Duty Nursing]	
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible**] [Not covered.]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible]** [Not covered.]
[Maximum number of shifts per calendar year for *inpatient and outpatient treatment*]	[5-70]
[Maximum per shift for *inpatient and outpatient treatment*]	[$75-$100]
[Skilled Nursing Care]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [Not covered.]
[Maximum per calendar year]	[5-70 Private Duty Nursing Shifts]
[Hospice Care Facility Expenses]	
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]
[Maximum per [calendar year] [lifetime]]	[15-45 days] [3-6 admissions]
[Maximum per day]	[$100-$300]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible**]
[Maximum per [calendar year] [lifetime] for *inpatient and outpatient treatment*]	[$1,500-$5,000]
[Other Outpatient Treatment Expenses]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible**]
[Maximum per visit]	[$50-$150]
[Maximum per [calendar year] [lifetime]]	[$500-$1,500] [3-6 visits]

[Schedule of Benefits]

[OTHER COVERED HEALTH CARE EXPENSES]	
PLAN FEATURES	
[Acupuncture]	
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**] [Not covered.]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]
[Maximum visits per calendar year]	[3-6]
[Maximum per calendar year for *inpatient and outpatient treatment*]	[$500-$1,500]
[Spinal Manipulation, Physical Therapy and Acupuncture Services Expenses]	
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**]
[Maximum per calendar year]	[$10,000-$30,000]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum per calendar year]	[$1,000-$3,000]
[Ambulance Service]	
[Air, Water or Ground Ambulance]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per trip]
[Maximum per calendar year]	[$250-$350**]**
[Covered as any other inpatient **hospital** expense if the covered person is admitted to the **hospital**] [Covered as any other outpatient **hospital** expense if the covered person is not admitted to the **hospital**]	

[Schedule of Benefits]

PLAN FEATURES	
[**Diagnostic, Genetic and Preoperative Testing:**]	
[Diagnostic Complex Imaging Expenses]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit]
[Maximum per calendar year]	[$250-$700] [1-10 procedures]
[Outpatient Diagnostic Lab Work and Radiological Services]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit]
[Maximum per calendar year]	[$250-$700] [1-10 procedures]
[Genetic Testing Expenses]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit]
[Maximum per calendar year]	[$250-$700] [1-10 procedures]
[Outpatient Diagnostic Radiological Services]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit]
[Maximum per calendar year]	[$100-$300]
[Outpatient Preoperative Testing]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit]
[Maximum per calendar year]	[$150-$450]
[Diagnostic Lab and X-rays (including Complex Imaging)]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit]
[Maximum number of services per calendar year]	[5-15]
[Maximum per calendar year]	[$600-$850]

[Schedule of Benefits]

PLAN FEATURES	
[Durable Medical and Surgical Equipment]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per item]
[Maximum per item]	[$100-$300]
[Maximum per [calendar year] [lifetime]]	[$100-$3,000]
[Experimental or Investigational Treatment]	[Payable as any other **covered expense** provided that *all* of the plan conditions are met.]
[Maternity Expenses] [Pregnancy Complications]	[Payable as any other **covered expense**.]
[Outpatient Prescription Drugs]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$60 **deductible** per **prescription**] [Not covered.]
[Maximum per **prescription**]	[$10-$50]
[Maximum number of **prescriptions** per calendar year]	[24-36]
[Maximum per month]	[$35-$200]
[Maximum per calendar year]	[$150-$3,000]
[Prosthetic Devices]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per item] [Not covered.]
[Short-Term Rehabilitation Therapy Services:]	
[Outpatient Speech Therapy]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$250-$750] [6-18 visits]

[Schedule of Benefits]

PLAN FEATURES	
[Outpatient Physical Therapy – (including spinal manipulation)]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$250-$750] [6-18 visits]
[Outpatient Occupational Therapy]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$250-$750] [6-18 visits]
[Reconstructive [or Cosmetic] Surgery and Supplies]	
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime] for *inpatient and outpatient treatment]*	[$100-$3,000]

[Schedule of Benefits]

[SPECIALIZED CARE]	
PLAN FEATURES	
[Chemotherapy]	
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime] for *inpatient and outpatient treatment*]	[$1,000-$3,000]
[Radiation Therapy]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$1,000-$3,000]
[Outpatient Infusion Therapy]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$1,000-$3,000]
[Cancer Treatment]	
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum per calendar year for *inpatient and outpatient treatment*]	[$2,000-$3,000*]
	[*This maximum will be reduced by charges incurred for **covered expenses** for the treatment of any other **illness** or **injury** but only up to the Plan's overall calendar year maximum benefit.]

[Schedule of Benefits]

PLAN FEATURES	
Diabetic Equipment, Supplies and Education	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per item] [Not covered.]
[Maximum per item]	[$50-$150]
[Maximum per [calendar year] [lifetime]]	[$500-$1,500]
[Basic Infertility Expenses]	[Payable as any other covered expense.*]
[*Coverage is limited only to the diagnosis and treatment of the underlying medical condition causing the infertility.]	
[Marriage, Family and Child Counseling]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$250-$750] [6-18 visits]
[Spinal Manipulation Treatment]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$100-$1,000] [2-18 visits]
[Treatment of Jaw Joint Disorders]	
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]

[Schedule of Benefits]

PLAN FEATURES	
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[6-18 visits]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime] for *inpatient and outpatient treatment*]	[$250-$750]
[Treatment of Cleft Lip or Palate [of Dependent Children Under Age 18]]	[Payable as any other **covered expense**.]
[Treatment of Speech Loss or Impairment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Transplant Services]	
[Inpatient Treatment]	
[Facility Expenses]	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[[Physician] [Specialist] Services]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**] [Not covered.]
[Outpatient Treatment]	
[Facility Expenses]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible**] [Not covered.]
[[Physician] [Specialist] Services (including office visits)]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum benefit per lifetime*]	[30-90 days] [$1,000-$12,000]
[*Applies to all transplant benefits incurred while covered under any **Aetna** or **Aetna-**affiliated plan.]	

[Schedule of Benefits]

[TREATMENT OF ALCOHOLISM, DRUG ABUSE [SUBSTANCE ABUSE] AND MENTAL DISORDERS]	
PLAN FEATURES	
[Mental Health]	
*[Inpatient Treatment] [**Serious**] [**Biologically-Based**] Mental Illness]*	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[Maximum per day]	[$200-$600]
[Maximum per [calendar year] [lifetime]	[15-45 days] [$500-$4,500] [3-9 admissions]
[Maximum per [calendar year] [lifetime] [combined with outpatient [**serious] [biologically-based] mental illness**]	[$500-$6,000]
*[Inpatient Treatment] [**Non-Serious**] [**Non-Biologically-Based**] Mental Illness]*	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[Maximum per day]	[$200-$600]
[Maximum per [calendar year] [lifetime]	[15-45 days] [$500-$4,500] [3-9 admissions]
[Maximum per [calendar year] [lifetime] [combined with outpatient [**non-serious] [non-biologically-based] mental illness**]	[$500-$6,000]
*[Outpatient Treatment] [**Serious**] [**Biologically-Based**] Mental Illness]*	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per office visit]	[$50-$150]
[Maximum per [calendar year] [lifetime]	[$250-$750] [2-6 visits]
[Maximum per [calendar year] [lifetime] [(combined with the inpatient [**serious] [biologically-based] mental illness**]	[$500-$6,000]
*[Outpatient Treatment] [**Non-Serious**] [**Non-Biologically-Based**] Mental Illness]*	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per office visit]	[$50-$150]
[Maximum per [calendar year] [lifetime]	[$250-$750] [2-6 visits]
[Maximum per calendar year] [lifetime] [(combined with the inpatient [**serious] [biologically-based] mental illness**]	[$500-$6,000]

[Schedule of Benefits]

[Substance Abuse] [Alcoholism] [, and] [Drug Abuse/Addiction Treatment]	
[Inpatient Rehabilitation and Detoxification Treatment]	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[Maximum per day]	[$200-$600]
[Maximum per [calendar year] [lifetime]	[15-45 days] [$500-$4,500] [3-9 admissions]
[Maximum per [calendar year] [lifetime] [combined with outpatient [**serious**] [**biologically-based**] **mental illness**]	[$500-$6,000]
[Inpatient Detoxification Treatment Only]	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered]
[Maximum per day]	[$200-$600]
[Maximum per [calendar year] [lifetime]	[15-45 days] [$500-$1,500] [3-9 admissions]
[Maximum per [calendar year] [lifetime] [(combined with the inpatient [rehabilitation]	[$500-$6,000]
[Outpatient Rehabilitation and Detoxification Treatment]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per office visit]	[$50-$150]
[Maximum per [calendar year] [lifetime]	[$500-$1,500] [3-9 visits]
[Maximum per [calendar year] [lifetime] [(combined with the inpatient]	[$500-$6,000]
[Outpatient Detoxification Treatment]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per office visit]	[$50-$150]
[Maximum per [calendar year] [lifetime]	[$500-$1,500] [3-9 visits]
[Maximum per [calendar year] [lifetime] [(combined with the outpatient [rehabilitation]	[$500-$6,000]

[Schedule of Benefits]

[Alcoholism and Drug Abuse] [Substance Abuse] [Treatment]	
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]
[Maximum per calendar year]	[$10,000-$30,000]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum visits per calendar year]	[60-180]
[Maximum benefit per visit]	[$35-$105]
[Maximum **occurrences** per lifetime for *inpatient and outpatient treatment*]	[1-3]

[Schedule of Benefits]

PLAN FEATURES	
[Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)]	[50%-100% after the Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum per visit]	[$50-$150]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$250-$750] [6-18 visits]

[Schedule of Benefits]

PLAN FEATURES	
[Inpatient Supplemental Medical Expense Benefits]	[50%-100%]
[Maximum benefit per lifetime]	[$45,000-$100,000]
[Supplementary Inpatient Hospital Expense Benefits]	[50%-100% after a $0-$200 **deductible** per **occurrence**]
[Maximum benefit per day]	[$300-$600]
[Maximum benefit per confinement]	[5-10 days per **occurrence**]
[Supplementary Maternity Expense Benefits]	[50%-100% after a $0-$200 **deductible** per **occurrence**]
[Maximum benefit per day]	[$300-$600]
[Maximum benefit per confinement]	[5-10 days per **occurrence**]
[Maximum benefit for maternity expenses]	[$1,000-$2,000 per **occurrence**]
[Supplementary Surgical Expense Benefits]	[50%-100% after a $0-$200 **deductible** per **occurrence**]
[Surgical maximum benefit per **occurrence**]	[$1,000-$2,000]

[Schedule of Benefits]

PLAN FEATURES	
[Supplementary Accident Expense Benefits]	[50%-100% after a $0-$200 **deductible** per **occurrence**]
[Maximum **occurrences** per calendar year]	[1-5]
[Maximum benefit per **occurrence**]	[$300-$10,000]
[Maximum benefit per calendar year]	[$300-$10,000]
[Injuries Resulting From A Motor Vehicle Accident]	[Payable on the same basis as any other **injury** except as provided below.]
[Maximum benefit per calendar year]	[$10,000-$30,000*]
[*This is the most the plan will pay in a calendar year for **covered expenses** incurred for the treatment of **injuries** resulting from a **motor vehicle accident**.]	
[Injuries Due To Participating in Collegiate and Intercollegiate Sports]	[Payable on the same basis as any other **injury** except as provided below.]
[Maximum benefit per calendar year]	[$5,000-$15,000*]
	[*This is the most the plan will pay in a calendar year for **covered expenses** incurred for the treatment of **injuries** resulting from the play or practice in collegiate and intercollegiate sports.]
[Injuries to Sound Natural Teeth]	[Payable on the same basis as any other **injury** except as provided below.]

[Schedule of Benefits]

PLAN FEATURES	
[Maximum benefit per calendar year]	[$250-$750, per tooth*]
[*This is the most the plan will pay in a calendar year for **covered expenses** incurred for the treatment of **injuries** to sound natural teeth.]	

All Other Expenses	
(Applies to all other expenses not otherwise shown above.)	[50%-100%] after any applicable **deductible]**

[Policyholder: ABC Company
Group Policy Number: 12345
Effective Date: January 1, 2004]

Aetna Life Insurance Company
Preferred Provider Organization (PPO)
[Limited] [Major] [Comprehensive] [Outpatient Only] [Accident Only] Medical Expense Coverage
[Schedule of Benefits]
PLAN FEATURES

Please read these materials carefully as the plan of benefits described in this Booklet-Certificate is limited [to outpatient expenses] [to **accident** expenses] and contains a number of specific limits on visits, services and dollar amounts, in addition to overall dollar maximum benefits payable under the policy. Once these limits have been reached, the plan will not pay any more towards the cost of the services in question and you will be responsible for the remaining unpaid charges or expenses. This Booklet-Certificate explains these visit and service limits, the overall annual benefit maximum, and other cost sharing features of your plan, such as **copayments** and **deductibles**.

[Unless otherwise indicated, any applicable **copay** or **deductible** must be met before benefits are paid.]

Calendar Year Deductibles
[Applies to all Covered Medical Expenses]

PLAN FEATURES	[NETWORK]	[OUT OF NETWORK]	[OTHER HEALTH CARE]
[Calendar Year **Deductible]**	[$0-$600]	[$0-$600]	[$0-$600]
*[Family **Deductible** Limit]*	[$0-$1,800]	[$0-$1,800]	[$0-$1,800]
[Inpatient Calendar Year **Deductible]**	[$0-$500]	[$0-$500]	[$0-$500]
*[Family **Deductible** Limit]*	[$0-$1,500]	[$0-$1,500]	[$0-$1,500]
[**Covered expenses** incurred as a result of an **accident** and applied to this **deductible** apply to satisfy the Accident Calendar Year **Deductible**.]			
[Outpatient Calendar Year **Deductible]**	[$0-$400]	[$0-$400]	[$0-$400]
*[Family **Deductible** Limit]*	[$0-$1,200]	[$0-$1,200]	[$0-$1,200]
[Hospital Emergency Room Calendar Year **Deductible]**	[$0-$500]	[$0-$500]	[$0-$500]

[Schedule of Benefits]

PLAN FEATURES	[NETWORK]	[OUT OF NETWORK]	[OTHER HEALTH CARE]
[Accident Calendar Year **Deductible]**	[$0-$250]	[$0-$250]	[$0-$250]
[**Covered expenses** incurred as a result of an **accident** and applied to the Inpatient Calendar Year **Deductible** apply to satisfy this **deductible**.]			

[Schedule of Benefits]

[Calendar Year][and Monthly] Maximum Benefits

[Calendar Year Maximum Benefit]	[$1,000-$150,000*]
[The most the plan will pay for **covered expenses** incurred by any one covered person in a [calendar] year is called the Calendar Year Maximum Benefit.]	

[*$500-$15,000 of this maximum is reserved for outpatient expenses.]

[Supplemental Calendar Year Maximum Benefit]	[$1,000-$45,000]
[If a covered person has exhausted their Calendar Year Maximum Benefit, an additional benefit may be paid for **covered expenses** incurred by any one covered person in a calendar year.]	

[Inpatient Calendar Year Maximum Benefit]	[$500-$50,000]

[The most the plan will pay for **covered expenses** incurred by any one covered person in a calendar year for charges [made by **network** and **out-of-network providers** and **other health care** providers] for **room and board** and other services or supplies given to the person during a **stay** in a **hospital** or other facility is called the Inpatient Calendar Year Maximum Benefit**.** The Inpatient Calendar Year Maximum Benefit is reduced by benefits paid and applied toward the Physician Expenses, Hospital Expenses, and Facility Expenses maximums. Refer to the Physician Expenses, Hospital Expenses, and Facility Expenses benefits in this Schedule of Benefits for applicable maximum amounts.**]**

[If a covered person has exhausted this maximum in a calendar year, an additional benefit may be paid in that calendar year if the person has a **stay** in a **hospital** or other facility. The additional benefit is the Inpatient Supplemental Medical Benefit.]

[Outpatient Calendar Year Maximum Benefit]	[$200-$15,000]

[The most the plan will pay for **covered expenses** incurred by any one covered person in a calendar year for charges [made by **network** and **out-of-network** p**roviders** and **other health care** providers] for services or supplies given to the person while *not* confined as a full-time inpatient is called the Outpatient Calendar Year Maximum Benefit.]

[Outpatient Calendar Year Maximum Visits]	[2-10]

[The calendar year maximum benefits apply to [network], [out-of-network] and **other health care** expenses combined.]

[The calendar year maximum benefits do not apply to [network] and **other health care** expenses. However, the calendar year maximum benefits apply to [out-of-network] expenses.]

[The calendar year maximum benefits [do] [do not] apply to the "[basic] [and] [limited] [major] [special] [comprehensive] [medical] [dental] [vision] [hearing] [**prescription drug**] expense coverage" described in the Booklet-Certificate.]

[Schedule of Benefits]

As indicated below, the calendar year maximum benefits will not deny benefits for certain **covered expenses** in any one calendar year.

[Outpatient Prescription Drug Calendar Year Maximum Benefit	$150-$3,000

The most the plan will pay for outpatient **prescription drug** expenses incurred by any one covered person in a calendar year is called the Outpatient Prescription Drug Calendar Year Maximum Benefit. Covered **prescription drug** expenses [will] [will not] be applied toward the Outpatient Calendar Year Maximum Benefit.]

[Outpatient Prescription Drug Monthly Maximum Benefit	$35-$200

The most the plan will pay for outpatient **prescription drug** expenses incurred by any one covered person in a month is called the Outpatient Prescription Drug Calendar Year Maximum Benefit. Covered **prescription drug** expenses [will] [will not] be applied toward the Outpatient Calendar Year Maximum Benefit.

[Schedule of Benefits]

Lifetime Maximum Benefits

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[*Lifetime Maximum Benefit* **(For Persons *Not* Eligible For Medicare)**]	[$5,000-$500,000]	[$5,000-$500,000]	[$5,000-$500,000]

[*Lifetime Maximum Benefit* **(For Persons *Not* Eligible For Medicare)**]	[For each **illness** or **injury**,] [$50,000-$500,000 or 52-104 weeks, whichever maximum is reached first*]	[For each **illness** or **injury**,] [$50,000-$500,000 or 52-104 weeks, whichever maximum is reached first*]	[For each **illness** or **injury**,] [$50,000-$500,000 or 52-104 weeks, whichever maximum is reached first*]
	[*Applies to all expenses except those incurred for treatment of **injuries** resulting from a **motor vehicle** accident and **injuries** resulting from play or practice in collegiate and intercollegiate sports.]	[*Applies to all expenses except those incurred for treatment of **injuries** resulting from a **motor vehicle** accident and **injuries** resulting from play or practice in collegiate and intercollegiate sports.]	[*Applies to all expenses except those incurred for treatment of **injuries** resulting from a **motor vehicle** accident and **injuries** resulting from play or practice in collegiate and intercollegiate sports.]

[*Lifetime Maximum Benefit* **(For Persons Eligible For Medicare)**]	[$5,000-$500,000]	[$5,000-$500,000]	[$5,000-$500,000]

[*Lifetime Maximum Benefit* **(For Persons Eligible For Medicare)**]	[For each **illness** or **injury**,] [$50,000-$500,000 or 52-104 weeks, whichever maximum is reached first*]	[For each **illness** or **injury**,] [$50,000-$500,000 or 52-104 weeks, whichever maximum is reached first*]	[For each **illness** or **injury**,] [$50,000-$500,000 or 52-104 weeks, whichever maximum is reached first*]
	[*Applies to all expenses except those incurred for treatment of **injuries** resulting from a **motor vehicle** accident and **injuries** resulting from play or practice in collegiate and intercollegiate sports.]	[*Applies to all expenses except those incurred for treatment of **injuries** resulting from a **motor vehicle** accident and **injuries** resulting from play or practice in collegiate and intercollegiate sports.]	[*Applies to all expenses except those incurred for treatment of **injuries** resulting from a **motor vehicle** accident and **injuries** resulting from play or practice in collegiate and intercollegiate sports.]

[Policyholder: ABC Company
Group Policy Number: 12345
Effective Date: January 1, 2004]

[Schedule of Benefits]

[The most the plan will pay for **covered expenses** incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.]

[The Lifetime Maximum Benefit applies to [network], [out-of-network] and **other health care** expenses combined.]

[The Lifetime Maximum Benefit [does] [does not] apply to [network] and **other health care** expenses. However, a Lifetime Maximum Benefit applies to [out-of-network] expenses.]

[The Lifetime Maximum Benefit [does] [does not] apply to the "[basic] [and] [limited] [major] [special] [comprehensive] [medical] [dental] [vision] [hearing] [**prescription drug**] expense coverage" described in the Booklet-Certificate.]

[As indicated below, the Lifetime Maximum Benefit will not deny benefits for certain **covered expenses**.]

[Lifetime Maximum Benefit Automatic Yearly Restoration

On [January 1st] of each year, the amount up to [$200-$1,000] which has been counted against your Lifetime Maximum Benefit will automatically be restored without action on your part. [Evidence of good health] will not be required. However, your insurance must be in force and restoration is not available during the extended insurance period. It will not provide benefits for **covered expenses** incurred before the date the Lifetime Maximum Benefit is restored.]

[Schedule of Benefits]

[The **coinsurance** listed in the [*Schedule of Benefits*] below reflects the Plan **Coinsurance**. This is the amount **Aetna** pays. You are responsible to pay any **deductibles** and remaining **coinsurance** percentage. You are responsible for full payment of any non-covered expenses you incur.]

[ALL COVERED EXPENSES ARE SUBJECT TO ANY APPLICABLE CALENDAR YEAR DEDUCTIBLE UNLESS OTHERWISE NOTED IN THE [*SCHEDULE OF BENEFITS*] BELOW.]

PLAN FEATURES

[Treatment of Injuries Related to an Accident Expense Benefit]			
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Inpatient Treatment]	[50%-100% after the$0-$50 **copay** per **occurrence** and Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible**, and Accident Calendar Year **Deductible,** and a $0-$50 per admission **copay**]	[50%-100% after the $0-$50 **deductible** per **occurrence** and Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible**, and the Accident Calendar Year **Deductible,** and a $0-$50 per admission **deductible**]	[50%-100% after the $0-$50 **deductible** per **occurrence** and Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible**, and Accident Calendar Year **Deductible,** and a $0-$50 per admission **deductible**]
[Additional Inpatient Benefits]	[50%-100% after the $0-$50 **copay** per **occurrence** and Calendar Year **Deductible**, and Inpatient Calendar Year **Deductible**, and Accident Calendar Year **Deductible]**	[50%-100% after the $0-$50 **deductible** per **occurrence** and Calendar Year **Deductible**, and Inpatient Calendar Year Deductible, and Accident Calendar Year **Deductible]**	[50%-100% after the $0-$50 **deductible** per **occurrence** and Calendar Year **Deductible**, and Inpatient Calendar Year D**eductible**, and Accident Calendar Year **Deductible]**
[Daily maximum benefit for **room and board**]	[$250-$2,000 per day, up to 20-30 days per calendar year]	[$250-$2,000 per day, up to 20-30 days per calendar year]	[$250-$2,000 per day, up to 20-30 days per calendar year]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Outpatient Treatment]	[50%-100% after the $0-$50 **copay** per **occurrence** and Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible**, and Accident Calendar Year **Deductible]**	[50%-100% after the $0-$50 **deductible** per **occurrence** and Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible**, and Accident Calendar Year **Deductible]**	[50%-100% after the$0-$50 **deductible** per **occurrence** and Calendar Year **Deductible**, and Outpatient Calendar Year **Deductible**, and Accident Calendar Year **Deductible]**
[Maximum per calendar year for *inpatient & outpatient treatment*]	[$300-$15,000*]	[$300-$15,000*]	[$300-$15,000*]
[*This maximum does not apply to **room and board** expenses.]			
[Maximum **occurrences** per calendar year for *inpatient & outpatient treatment*	[1-5]	[1-5]	[1-5]
Maximum benefit per **occurrence** for *inpatient & outpatient treatment*]	[$300-$10,000]	[$300-$10,000]	[$300-$10,000]

[Schedule of Benefits]

[Treatment of Non-Accident Related Conditions Expense Benefit]			
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **copay**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]
[Daily maximum benefit for **room and board]**	[$250-$2,000 per day, up to 20-30 days per calendar year]	[$250-$2,000 per day, up to 20-30 days per calendar year]	[$250-$2,000 per day, up to 20-30 days per calendar year]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]
[Maximum number of emergency room visits per calendar year]	[3-6]	[3-6]	[3-6]
[Maximum benefit per emergency room visit]	[$50-$100]	[$50-$100]	[$50-$100]
[Maximum physician office visits per calendar year]	[6-10*]	[6-10*]	[6-10*]
[*One office visit may be used for a routine physical or gynecological exam after a covered person has completed [1-6 months] of constant coverage under the Plan.]			
[Maximum benefit per physician office visit]	[$50-$100]	[$50-$100]	[$50-$100]
[Diagnostic Services]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Maximum number of services per calendar year]	[5-15]	[5-15]	[5-15]
[Maximum per service]	[$50-$100]	[$50-$100]	[$50-$100]

[Schedule of Benefits]

PLAN FEATURES			
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Routine Preventive Care Expenses Adults & Children]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum per calendar year]	[$100-$200]	[$100-$200]	[$100-$200]
[Family Planning Services]			
[*Voluntary Sterilization* (including tubal ligation and vasectomy)]			
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year Deductible and a $0-$50 per procedure **copay**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year Deductible and a $0-$50 per procedure **deductible**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year Deductible and a $0-$50 per procedure **deductible**]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 per procedure **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 per procedure **deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 per procedure **deductible**]
[Maximum per [calendar year] [lifetime] for *inpatient and outpatient treatment*]	[$100-$300]	[$100-$300]	[$100-$300]

[Schedule of Benefits]

PLAN FEATURES			
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Physician Expenses]			
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**]
[Maximum per calendar year for surgical services]	[$100-$4,000]	[$100-$4,000]	[$100-$4,000]
[Maximum per surgery for surgical assistance services]	Not more than [25%-50%] of the operating **physician**'s charges.	Not more than [25%-50%] of the operating **physician**'s charges.	Not more than [25%-50%] of the operating **physician**'s charges.
[Maximum per calendar year for anesthesia services]	[$100-$4,000]	[$100-$4,000]	[$100-$4,000]
[Maximum per physician visit to facility where you are confined]	[$35-$100]	[$35-$100]	[$35-$100]
[Outpatient Treatment (Non-Surgical Office Visit)]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [and a $0-$50 office visit **deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [and a $0-$50 office visit **deductible**]
[Maximum number of non-surgical office visits per calendar year]	[5-10]	[5-10]	[5-10]
[Maximum per non-surgical office visit]	[$35-$100]	[$35-$100]	[$35-$100]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Outpatient Treatment (Surgical Office Visit)]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [and a $0-$50 office visit **deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [and a $0-$50 office visit **deductible**]
[Maximum number of surgical office visits per calendar year]	[5-10]	[5-10]	[5-10]
[Maximum per surgical office visit]	[$35-$100]	[$35-$100]	[$35-$100]

[Diagnostic Laboratory and X-ray Expenses Performed in a Physician's Office [except for Complex Imaging Services] – (If performed as a part of a **physician's** office visit and billed by the **physician**; coverage of expenses is the same as a **physicians** office visit)]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [and a $0-$50 office visit **deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per calendar year]	[$25-$400] [1-5 procedures]	[$25-$400] [1-5 procedures]	[$25-$400] [1-5 procedures]
[Alternatives to Physician Office Visits]			
*[**E-visit** Online Consultation by a **PCP**]*	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] and a $0-$50 per visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 per visit **deductible**] [Not Covered]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 per visit **deductible**] [Not Covered]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
*[**Walk-In Clinic** Non-Emergency Visit Includes coverage for immunizations.]*	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 per visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 per visit **deductible**] [Not Covered]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 per visit **deductible**] [Not Covered]

[Maximum number of visits per calendar year]	[2-15]	[2-15] [Not Covered]	[2-15] [Not Covered]
[Maximum benefit per calendar year]	[$50-$500]	[$50-$500] [Not Covered]	[$50-$500] [Not Covered]

[Schedule of Benefits]

PLAN FEATURES			
[Hospital Expenses]			
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Inpatient Hospital Expenses]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar **Year Deductible** and a $0-$50 per admission **copay**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[Maximum per day]	[$200-$600]	[$200-$600]	[$200-$600]
[Outpatient Hospital Expenses (including surgery)]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **copay** per visit/surgical procedure]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit/surgical procedure] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit/surgical procedure] [Not covered.]
[Maximum per visit]	[$50-$200]	[$50-$200]	[$50-$200]
[Maximum per [calendar year] [lifetime]]	[$2,500-$8,000] [3-10 visits]	[$2,500-$8,000] [3-10 visits]	[$2,500-$8,000] [3-10 visits]
[Maximum per calendar year (applies to *inpatient and outpatient **hospital** expenses*)]	[$2,000-6,000*] [*This maximum does not apply to **room and board** expenses.]	[$2,000-6,000*] [*This maximum does not apply to **room and board** expenses.]	[$2,000-6,000*] [*This maximum does not apply to **room and board** expenses.]

[Schedule of Benefits]

PLAN FEATURES			
[Facility Expenses]			
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Inpatient Facility Expenses]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **copay**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]
[Daily maximum benefit for **room and board**]	[$200-$600]	[$200-$600]	[$200-$600]
[ICU maximum per day]	[$400-$600]	[$300-$500]	[$300-$500]
[Maximum per calendar year for other facility services and supplies]	[$500-$3,500]	[$500-$3,500]	[$500-$3,500]
[Maximum days per period of confinement]	[15-30]	[15-30]	[15-30]
[Daily maximum benefit]	[$300-$600 per day up to 5-10 days per period of confinement]	[$300-$600 per day up to 5-10 days per period of confinement]	[$300-$600 per day up to 5-10 days per period of confinement]
[Outpatient Facility Expenses]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]

[Schedule of Benefits]

PLAN FEATURES			
Coverage For Emergency Medical Conditions			
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Emergency Room]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and **Hospital** Emergency Room Calendar Year **Deductible** and a $0-$100 **copay** per emergency room visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and **Hospital** Emergency Room Calendar Year **Deductible** and a $0-$100 **deductible** per emergency room visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and **Hospital** Emergency Room Calendar Year **Deductible** and a $0-$100 **deductible** per emergency room visit]
[Maximum number of visits per calendar year]	[3-6]	[3-6]	[3-6]
[Maximum per visit]	[$35-$150]	[$35-$150]	[$35-$150]
[Maximum per calendar year]	[$500-$5,000]	[$500-$5,000]	[$500-$5,000]
Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered	Not covered

[If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your emergency room per visit [**copay**] [or **deductible**] is waived.]

[**Covered expenses** that are applied to the **hospital** Emergency Room Calendar Year **Deductible** or emergency room per visit [**copay**] [or **deductible**] cannot be applied to any other [**copays**] [or **deductibles**] under your plan. Likewise, **covered expenses** that are applied to any of your plan's other [**copays**] [or **deductibles]** cannot be applied to the Emergency Room Calendar Year **Deductible** or emergency room per visit [**copay**] [or **deductible**].]

[Schedule of Benefits]

PLAN FEATURES			
[ALTERNATIVES TO HOSPITAL STAYS]			
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Outpatient Surgery and Physician's Services]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **copay** per surgery]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per surgery] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per surgery] [Not covered.]
[Outpatient Diagnostic and Surgical Services Expenses]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **copay** per service]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per service]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per service]
[Maximum number of services per calendar year]	[5-15]	[5-15]	[5-15]
[Maximum per calendar year]	[$200-$2,000]	[$200-$2,000]	[$200-$2,000]
[Maximum per calendar year]	[the first to occur of 5-15 visits or $200-$2,000]	[the first to occur of 5-15 visits or $200-$2,000]	[the first to occur of 5-15 visits or $200-$2,000]
[Birthing Center and Physician's Services]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **copay** per birth]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per birth] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per birth] [Not covered.]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[**Home Health Care]**	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [Not covered.]
[Maximum number of visits per calendar year]	[15-60 visits]	[15-60 visits]	[15-60 visits]
[Maximum number of visits per lifetime]	[60-120]	[60-120]	[60-120]
[Maximum number of visits per day]	[1-4]	[1-4]	[1-4]
[Skilled Nursing Facility]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar **Year Deductible** and a $0-$50 per admission **copay**]	[50%-100% after the Calendar Year **Deductible** and Intpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[Maximum per day]	[$200-$600]	[$200-$600]	[$200-$600]
[Maximum per [calendar year] [lifetime]]	[15-45 days] [$15,000-$45,000] [3-9 admissions]	[15-45 days] [$15,000-$45,000] [3-9 admissions]	[15-45 days] [$15,000-$45,00] [3-9 admissions]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Private Duty Nursing]			
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**] [Not covered.]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible]** **[**Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible]** [Not covered.]
[Maximum number of shifts per calendar year for *inpatient and outpatient treatment*]	[5-70]	[5-70]	[5-70]
[Maximum per shift for *inpatient and outpatient treatment*]	[$75-$100]	[$75-$100]	[$75-$100]
[Skilled Nursing Care]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [Not covered.]
[Maximum per calendar year]	[5-70 Private Duty Nursing Shifts]	[5-70 Private Duty Nursing Shifts]	[5-70 Private Duty Nursing Shifts]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Hospice Care Facility Expenses]			
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **copay**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[Maximum per [calendar year] [lifetime]]	[15-45 days] [3-6 admissions]	[15-45 days] [3-6 admissions]	[15-45 days] [3-6 admissions]
[Maximum per day]	[$100-$300]	[$100-$300]	[$100-$300]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]
[Maximum per [calendar year] [lifetime] for *inpatient and outpatient treatment*]	[$1,500-$5,000]	[$1,500-$5,000]	[$1,500-$5,000]
[Other Outpatient Treatment Expenses]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]
[Maximum per visit]	[$50-$150]	[$50-$150]	[$50-$150]
[Maximum per [calendar year] [lifetime]]	[$500-$1,500] [3-6 visits]	[$500-$1,500] [3-6 visits]	[$500-$1,500] [3-6 visits]

[Schedule of Benefits]

PLAN FEATURES			
[OTHER COVERED HEALTH CARE EXPENSES]			
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Acupuncture]			
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**] [Not covered.]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **copay**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]	[$50-$150]	[$50-$150]
[Maximum visits per calendar year]	[3-6]	[3-6]	[3-6]
[Maximum per calendar year for *inpatient and outpatient treatment*]	[$500-$1,500]	[$500-$1,500]	[$500-$1,500]
[Spinal Manipulation, Physical Therapy and Acupuncture Services Expenses]			
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**]
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Maximum per calendar year]	[$10,000-$30,000]	[$10,000-$30,000]	[$10,000-$30,000]

[Schedule of Benefits]

[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum per calendar year]	[$1,000-$3,000]	[$1,000-$3,000]	[$1,000-$3,000]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Ambulance Service]			
[Air, Water or Ground Ambulance]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [and a $0-$50 **copay** per trip]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [and a $0-$50 **deductible** per trip]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] [and a $0-$50 **deductible** per trip]
[Maximum per calendar year]	[$250-$350**]**	[$250-$350**]**	[$250-$350**]**
[Covered as any other inpatient hospital expense if the covered person is admitted to the **hospital**.] [Covered as any other outpatient hospital expense if the covered person is not admitted to the **hospital**.]			
[Diagnostic, Genetic and Preoperative Testing:]			
[Diagnostic Complex Imaging Expenses]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **copay** per visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductibl**e per visit] [Not covered.]
[Maximum per calendar year]	[$250-$700] [1-10 procedures]	[$25-$700] [1-10 procedures]	[$250-$700] [1-10 procedures]
[Outpatient Diagnostic Lab Work and Radiological Services]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **copay** per visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit] [Not covered]
[Maximum per calendar year]	[$250-$750] [1-10 procedures]	[$250-$750] [1-10 procedures]	[$250-$750] [1-10 procedures]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Genetic Testing Expenses]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **copay** per visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit] [Not covered.]
[Maximum per calendar year]	[$250-$750] [1-10 procedures]	[$250-$750] [1-10 procedures]	[$250-$750] [1-10 procedures]
[Outpatient Diagnostic Radiological Services]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **copay** per visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit] [Not covered.]
[Maximum per calendar year]	[$100-$300]	[$100-$300]	[$100-$300]
[Outpatient Preoperative Testing]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **copay** per visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit] [Not covered.]
[Maximum per calendar year]	[$150-$450]	[$150-$450]	[$150-$450]
[Diagnostic Lab and X-rays (including Complex Imaging)]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **copay** per visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per visit]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Maximum number of services per calendar year]	[5-15]	[5-15]	[5-15]
[Maximum per calendar year]	[$600-$850]	[$600-$850]	[$600-$850]
[Durable Medical and Surgical Equipment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **copay** per item]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per item]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per item] [Not covered]
[Maximum per item]	[$100-$300]	[$100-$300]	[$100-$300]
[Maximum per [calendar year] [lifetime]]	[$100-$3,000]	[$100-$3,000]	[$100-$3,000]
[Experimental or Investigational Treatment]	[Payable as any other **covered expense** provided that *all* of the plan conditions are met.]	[Payable as any other **covered expense** provided that *all* of the plan conditions are met.]	[Payable as any other **covered expense** provided that *all* of the plan conditions are met.]
Maternity Expenses [Pregnancy Complications]	[Payable as any other **covered expense**.]	[Payable as any other **covered expense**.]	[Payable as any other **covered expense**.]
[Outpatient Prescription Drugs]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$60 **copay** per **prescription**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$60 **deductible** per **prescription**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$60 **deductible** per **prescription**] [Not covered.]
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**

[Schedule of Benefits]

[Maximum per prescription]	[$10-$50]	[$10-$50]	[$10-$50]
[Maximum number of prescriptions per calendar year]	[24-36]	[24-36]	[24-36]
[Maximum per calendar year]	[$150-$3,000]	[$150-$3,000]	[$150-$3,000]
[Maximum per month]	[$35-$200]	[$35-$200]	[$35-$200]
[Prosthetic Devices]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **copay** per item]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per item] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per item] [Not covered.]
[Short-Term RehabilitationTherapy Services:]			
[Outpatient Speech Therapy]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]	[$50-$150]	[$50-$150]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$250-$750] [6-18 visits]	[$250-$750] [6-18 visits]	[$250-$750] [6-18 visits]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Outpatient Physical Therapy – (including spinal manipulation)]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]	[$50-$150]	[$50-$150]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$250-$750] [6-18 visits]	[$250-$750] [6-18 visits]	[$250-$750] [6-18 visits]
[Outpatient Occupational Therapy]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]	[$50-$150]	[$50-$150]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$250-$750] [6-18 visits]	[$250-$750] [6-18 visits]	[$250-$750] [6-18 visits]
[Reconstructive [or Cosmetic] Surgery and Supplies]			
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **copay**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Outpatient Treatment]	[50%-100% after the	[50%-100% after the	[50%-100% after the

[Schedule of Benefits]

	Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**] and a $0-$50 office visit **copay**]	Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]	Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime] for *inpatient and outpatient treatment*]	[$100-$3,000]	[$100-$3,000]	[$100-$3,000]

[Schedule of Benefits]

PLAN FEATURES			
[SPECIALIZED CARE]			
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Chemotherapy]			
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **copay**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime] for *inpatient and outpatient treatment]*	[$1,000-$3,000]	[$1,000-$3,000]	[$1,000-$3,000]
[Radiation Therapy]	[50% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$1,000-$3,000]	[$1,000-$3,000]	[$1,000-$3,000]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Outpatient Infusion Therapy]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$1,000-$3,000]	[$1,000-$3,000]	[$1,000-$3,000]
[Cancer Treatment]			
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **copay**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum per calendar year for *inpatient and outpatient treatment*]	[$2,000-$3,000*]	[$2,000-$3,000*]	[$2,000-$3,000*]
[*This maximum will be reduced by charges incurred for **covered expenses** for the treatment of any other **illness** or **injury** but only up to the Plan's overall calendar year maximum benefit.]			

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
Diabetic Equipment, Supplies and Education	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **copay** per item]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per item] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 **deductible** per item] [Not covered.]
[Maximum per item]	[$50-$150]	[$50-$150]	[$50-$150]
[Maximum per [calendar year] [lifetime]]	[$500-$1,500]	[$500-$1,500]	[$500-$1,500]
[Basic Infertility Expenses]	[Payable as any other **covered expense**.*]	[Payable as any other **covered expense**.*]	[Payable as any other **covered expense**.*]
[*Coverage is limited only to the diagnosis and treatment of the underlying medical condition causing the infertility.]			
[Marriage, Family and Child Counseling]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]	[$50-$150]	[$50-$150]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$250-$750] [6-18 visits]	[$250-$750] [6-18 visits]	[$250-$750] [6-18 visits]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Spinal Manipulation Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]	[$50-$150]	[$50-$150]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$100-$1,000] [2-18 visits]	[$100-$1,000] [2-18 visits]	[$100-$1,000] [2-18 visits]
[Treatment of Jaw Joint Disorders]			
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **copay**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per visit]	[$50-$150]	[$50-$150]	[$50-$150]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[6-18 visits]	[6-18 visits]	[6-18 visits]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime] for *inpatient and outpatient treatment*]	[$250-$750]	[$250-$750]	[$250-$750]
[Treatment of Cleft Lip or Palate [of Dependent Children Under Age 18]]	[Payable as any other **covered expense**.]	[Payable as any other **covered expense**.]	[Payable as any other **covered expense**.]
[Treatment of Speech Loss or Impairment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **deductible**] [Not covered.]

[Schedule of Benefits]

[Transplant Services]			
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Inpatient Treatment]			
[Facility Expenses]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **copay**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[[Physician] [Specialist] Services]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible**] [Not covered.]
[Outpatient Treatment]			
[Facility Expenses]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible**] [Not covered.]
[[Physician] [Specialist] Services (including office visits)]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum benefit per lifetime*]	[30-90 days] [$1,000-$12,000]	[30-90 days] [$1,000-$12,000]	[30-90 days] [$1,000-$12,000]
[*Applies to all transplant benefits incurred while covered under any **Aetna** or **Aetna**-affiliated plan.]			

[Schedule of Benefits]

[TREATMENT OF ALCOHOLISM, DRUG ABUSE [SUBSTANCE ABUSE] AND MENTAL DISORDERS]			
	[IN-NETWORK]	**[OUT-OF-NETWORK]**	**[OTHER HEALTH CARE]**
[Mental Health]			
*[Inpatient Treatment **[Serious] [Biologically-Based] Mental Illness**]*	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **copay**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[Maximum per day]	[$200-$600]	[$200-$600]	[$200-$600]
[Maximum per [calendar year] [lifetime]	[15-45 days] [$500-$4,500] [3-9 admissions]	[15-45 days] [$500-$4,500] [3-9 admissions]	[15-45 days] [$500-$4,500] [3-9 admissions]
[Maximum per [calendar year] [lifetime] [combined with outpatient [**serious] [biologically-based] mental illness**]	[$500-$6,000]	[$500-$6,000]	[$500-$6,000]
*[Inpatient Treatment **[Non-Serious] [Non-Biologically-Based] Mental Illness]***	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **copay**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]

[Schedule of Benefits]

	[IN-NETWORK]	**[OUT-OF-NETWORK]**	**[OTHER HEALTH CARE]**
[Maximum per day]	[$200-$600]	[$200-$600]	[$200-$600]
[Maximum per [calendar year] [lifetime]	[15-45 days] [$500-$4,500] [3-9 admissions]	[15-45 days] [$500-$4,500] [3-9 admissions]	[15-45 days] [$500-$4,500] [3-9 admissions]
[Maximum per [calendar year] [lifetime] [combined with outpatient [**non-serious]** [**non-biologically-based] mental illness**]	[$500-$6,000]	[$500-$6,000]	[$500-$6,000]
*[Outpatient Treatment **[Serious] [Biologically-Based] Mental Illness]***	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **copay**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar **Year Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per office visit]	[$50-$150]	[$50-$150]	[$50-$150]
[Maximum per [calendar year] [lifetime]	[$250-$750] [2-6 visits]	[$250-$750] [2-6 visits]	[$250] [2-6 visits]
[Maximum per [calendar year] [lifetime] [(combined with the inpatient [**serious]** [**biologically-based] mental illness**]	[$500-$6,000]	[$500-$6,000]	[$500-$6,000]

[Schedule of Benefits]

	[IN-NETWORK]	**[OUT-OF-NETWORK]**	**[OTHER HEALTH CARE]**
*[Outpatient Treatment **[Non-Serious] [Non-Biologically-Based] Mental Illness]***	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **copay**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per office visit]	[$50-$150]	[$50-$150]	[$50-$150]
[Maximum per [calendar year] [lifetime]	[$250-$750] [2-6 visits]	[$250-$750] [2-6 visits]	[$250-$750] [2-6 visits]
[Maximum per calendar year] [lifetime] [(combined with the inpatient [**serious] [biologically-based] mental illness**]	[$500-$6,000]	[$500-$6,000]	[$500-$6,000]

[Schedule of Benefits]

[Substance Abuse] [Alcoholism] [, and] [Drug Abuse/Addiction Treatment]			
	[IN-NETWORK]	**[OUT-OF-NETWORK]**	**[OTHER HEALTH CARE]**
[Inpatient Rehabilitation and Detoxification Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **copay**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[Maximum per day]	[$200-$600]	[$200-$600]	[$200-$600]
[Maximum per [calendar year] [lifetime]	[15-45 days] [$500-$4,500] [3-9 admissions]	[15-45 days] [$500-$4,500] [3-9 admissions]	[15-45 days] [$500-$4,500] [3-9 admissions]
[Maximum per [calendar year] [lifetime] [combined with outpatient **[serious] [biologically-based] mental illness]**	[$500-$6,000]	[$500-$6,000]	[$500-$6,000]
[Inpatient Detoxification Treatment Only]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **copay**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**] [Not covered.]
[Maximum per day]	[$200-$600]	[$200-$600]	[$200-$600]
[Maximum per [calendar year] [lifetime]	[$500-$1,500] [15-45 days] [3-9 admissions]	[$500-$1,500] [15-45 days] [3-9 admissions]	[$500-$1,500] [15-45 days] [3-9 admissions]
[Maximum per [calendar year] [lifetime] [(combined with the inpatient [rehabilitation]	[$500-$6,000]	[$500-$6,000]	[$500-$6,000]

[Schedule of Benefits]

	[IN-NETWORK]	**[OUT-OF-NETWORK]**	**[OTHER HEALTH CARE]**
[Outpatient Rehabilitation and Detoxification Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **copay**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per office visit]	[$50-$150]	[$50-$150]	[$50-$150]
[Maximum per [calendar year] [lifetime]	[$500-$1,500] [3-9 visits]	[$500-$1,500] [3-9 visits]	[$500-$1,500] [3-9 visits]
[Maximum per [calendar year] [lifetime] [(combined with the inpatient]	[$500-$6,000]	[$500-$6,000]	[$500-$6,000]
[Outpatient Detoxification Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **copay**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**] [Not covered.]
[Maximum per office visit]	[$50-$150]	[$50-$150]	[$50-$150]
[Maximum per [calendar year] [lifetime]	[$500-$1,500] [3-9 visits]	[$500-$1,500] [3-9 visits]	[$500-$1,500] [3-9 visits]
[Maximum per [calendar year] [lifetime] [(combined with the outpatient [rehabilitation]	[$500-$6,000]	[$500-$6,000]	[$500-$6,000]
[Both in-network and out of network] [**substance abuse**] [alcoholism] [and] [drug abuse/addiction treatment expenses and [**mental illness**] treatment expenses [accumulate toward any maximum shown above for] [**substance abuse**] [alcoholism] [and] [drug abuse/addiction treatment expenses.]			

[Schedule of Benefits]

[Alcoholism and Drug Abuse] [Substance Abuse] [Treatment]			
	[IN-NETWORK]	**[OUT-OF-NETWORK]**	**[OTHER HEALTH CARE]**
[Inpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]	[50%-100% after the Calendar Year **Deductible** and Inpatient Calendar Year **Deductible** and a $0-$50 per admission **deductible**]
[Maximum per calendar year]	[$10,000-$30,000]	[$10,000-$30,000]	[$10,000-$30,000]
[Outpatient Treatment]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum visits per calendar year]	[60-180]	[60-180]	[60-180]
[Maximum benefit per visit]	[$35-$105]	[$35-$105]	[$35-$105]
[Maximum **occurrences** per lifetime for *inpatient and outpatient treatment*]	[1-3]	[1-3]	[1-3]

[Schedule of Benefits]

PLAN FEATURES			
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **copay**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]	[50%-100% after the Calendar Year **Deductible** and Outpatient Calendar Year **Deductible** and a $0-$50 office visit **deductible**]
[Maximum per visit]	[$50-$150]	[$50-$150]	[$50-$150]
[Maximum per [calendar year] [consecutive day benefit period] [condition] [lifetime]]	[$250-$750] [6-18 visits]	[$250-$750] [6-18 visits]	[$250-$750] [6-18 visits]

[Schedule of Benefits]

PLAN FEATURES			
	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Inpatient Supplemental Medical Expense Benefits]	[50%-100%]	[50%-100%]	[50%-100%]
[Maximum benefit per lifetime]	[$45,000-$100,000]	[$45,000-$100,000]	[$45,000-$100,000]
[Supplementary Inpatient Hospital Expense Benefits]	[50%-100% after a $0-$100 **copay** per **occurrence**]	[50%-100% after a $0-$200 **deductible** per **occurrence**]	[50%-100% after a $0-$200 **deductible** per **occurrence**]
[Maximum benefit per day]	[$300-$600]	[$300-$600]	[$300-$600]
[Maximum benefit per confinement]	[5-10 days per **occurrence**]	[5-10 days per **occurrence**]	[5-10 days per **occurrence**]
[Supplementary Maternity Expense Benefits]	[50%-100% after a $0-$100 **copay** per **occurrence**]	[50%-100% after a $0-$200 **deductible** per **occurrence**]	[50%-100% after a $0-$200 **deductible** per **occurrence**]
[Maximum benefit per day]	[$300-$600]	[$300-$600]	[$300-$600]
[Maximum benefit per confinement]	[5-10 days per **occurrence**]	[5-10 days per **occurrence**]	[5-10 days per **occurrence**]
[Maximum benefit for maternity expenses]	[$1,000-$2,000 per **occurrence**]	[$1,000-$2,000 per **occurrence**]	[$1,000-$2,000 per **occurrence**]
[Supplementary Surgical Expense Benefits]	[50%-100% after a $0-$100 **copay** per **occurrence**]	[50%-100% after a $0-$200 **deductible** per **occurrence**]	[50%-100% after a $0-$200 **deductible** per **occurrence**]
[Surgical maximum benefit per **occurrence**]	[$1,000-$2,000]	[$1,000-$2,000]	[$1,000-$2,000]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Supplementary Accident Expense Benefits]	[50%-100% after a $0-$100 **copay** per **occurrence**]	[50%-100% after a $0-$200 **deductible** per **occurrence**]	[50%-100% after a $0-$200 **deductible** per **occurrence**]
[Maximum **occurrences** per calendar year]	[1-5]	[1-5]	[1-5]
[Maximum benefit per **occurrence**]	[$300-$10,000]	[$300-$10,000]	[$300-$10,000]
[Maximum benefit per calendar year]	[$300-$10,000]	[$300-$10,000]	[$300-$10,000]
[Injuries Resulting From A Motor Vehicle Accident]	[Payable on the same basis as any other **injury** except as provided below.]	[Payable on the same basis as any other **injury** except as provided below.]	[Payable on the same basis as any other **injury** except as provided below.]
[Maximum benefit per calendar year]	[$10,000-$30,000*] [*This is the most the plan will pay in a calendar year for **covered expenses** incurred for the treatment of **injuries** resulting from a **motor vehicle accident**.]	[$10,000-$30,000*] [*This is the most the plan will pay in a calendar year for **covered expenses** incurred for the treatment of **injuries** resulting from a **motor vehicle accident**.]	[$10,000-$30,000*] [*This is the most the plan will pay in a calendar year for **covered expenses** incurred for the treatment of **injuries** resulting from a **motor vehicle accident**.]

[Schedule of Benefits]

	[NETWORK]	**[OUT OF NETWORK]**	**[OTHER HEALTH CARE]**
[Injuries Due To Participating in Collegiate and Intercollegiate Sports]	[Payable on the same basis as any other **injury** except as provided below.]	[Payable on the same basis as any other **injury** except as provided below.]	[Payable on the same basis as any other **injury** except as provided below.]
[Maximum benefit per calendar year]	[$5,000-$15,000*] [*This is the most the plan will pay in a calendar year for **covered expenses** incurred for the treatment of **injuries** resulting from the play or practice in collegiate and intercollegiate sports.]	[$5,000-$15,000*] [*This is the most the plan will pay in a calendar year for **covered expenses** incurred for the treatment of **injuries** resulting from the play or practice in collegiate and intercollegiate sports.]	[$5,000-$15,000*] [*This is the most the plan will pay in a calendar year for **covered expenses** incurred for the treatment of **injuries** resulting from the play or practice in collegiate and intercollegiate sports.]
[Injuries to Sound Natural Teeth]	[Payable on the same basis as any other **injury** except as provided below.]	[Payable on the same basis as any other **injury** except as provided below.]	[Payable on the same basis as any other **injury** except as provided below.]
[Maximum benefit per calendar year]	[$250-$750, per tooth*] [*This is the most the plan will pay in a calendar year for **covered expenses** incurred for the treatment of **injuries** to sound natural teeth.]	[$250-$750, per tooth*] [*This is the most the plan will pay in a calendar year for **covered expenses** incurred for the treatment of **injuries** to sound natural teeth.]	[$250-$750, per tooth*] [*This is the most the plan will pay in a calendar year for **covered expenses** incurred for the treatment of **injuries** to sound natural teeth.]
All Other Expenses			
(Applies to all other **covered expenses** not otherwise shown above.)	[50%-100%] after any applicable **copay** or **deductible**	[50%-100%] after any applicable **copay** or **deductible**	[50%-100%] after any applicable **copay** or **deductible**

When Coverage Ends

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to [reinstate or] continue coverage.

When Coverage Ends For [Employees]

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions. [See *Premium Contribution Provisions* for more information];
- [You become covered under another medical plan offered by your employer;]
- [You have exhausted your overall maximum lifetime benefit under your medical plan;] [or
- Your employment stops for any reason, including a job elimination or being placed on severance. This will be [either] the date you stop active work [, or the day before the first premium due date that occurs after you stop active work]. However, if premium payments are made on your behalf, **Aetna** may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:

    - If you are not **actively at work** due to **illness** or **injury**, [sabbatical] [or other authorized leave as agreed to by your policyholder and **Aetna**] your coverage may continue, until stopped by your [employer], [but not beyond three months from the start of the absence.] [Your coverage will not continue beyond the end of the next policy month after the policy month in which your absence started. A "policy month" is defined in the group policy on file with your employer.]

    - If you are not **actively at work** due to temporary lay-off or leave of absence, [sabbatical] [or other authorized leave as agreed to by your policyholder and **Aetna**] your coverage [may continue, until stopped by your employer] [will stop on the last full day you are **actively at work** before the start of the lay-off or leave of absence.] [Your coverage will not continue beyond the end of the next policy month after the policy month in which your absence started but not beyond one month from the start of the absence.] A "policy month" is defined in the group policy on file with your employer.]

    - [If you are eligible as a permanently and totally disabled employee under the terms of the *Eligibility* section, your coverage may be deemed to continue for Life Insurance while you remain eligible under that section.
      [Accidental death] [Accidental death and personal loss] coverage will not be continued.]

- [If you are not **actively at work** because your job has been eliminated, you have been placed on severance, or this Plan allows former employee to continue their coverage, then coverage under this Plan may continue in accordance with the terms of this Plan's continuation provisions. See the terms of the *Continuation* section.]

[It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.]

[Reinstating Coverage for Short Term and Long Term Disability]

[If your short or long term disability coverage ends, you may reinstate [coverage] [the coverage you previously had in effect] subject to the rules described in the *When your Coverage Begins* section.]

[However, if your coverage ends because you stop active work due to a military or approved family medical leave of absence, you may reinstate [coverage] [the coverage you previously had in effect] without having to complete a new eligibility probationary period, if you return to active work in an *Eligible Class* within one month of the date your coverage ended.]

[In addition, if you return to work in an *Eligible Class* within one month of the date your coverage ended, the pre-existing condition rule applies to the extent the rule would have applied if your coverage had not ended.]

[However, if your coverage ends because you stop active work due to a military or approved family medical leave of absence, any pre-existing condition rule applies to the extent the rule would have applied if your coverage had not ended, providing you return to work in an *Eligible Class* within one months of the date your coverage ended.]

[For the above exceptions to apply, you must request to reinstate contributory coverage within 31 days of your return to active work.]

[If you want to change your coverage to a different plan option, your employer will provide you with the information on how and when changes can be made. A change that increases your coverage may require that you provide evidence of good health. See *Evidence of Good Health* for more information. The Special Rules as to an Increase in Coverage also apply as described in the *Pre-existing Conditions* section.]

[Reinstatement After Your Dental Coverage Terminates

If your coverage ends because your contributions are not paid when due, you may not be covered again for a period of two years from the date your coverage ends. If you are in an eligible class, you may re-enroll yourself and your eligible dependents at the end of such two-year period. Your dental coverage will be subject to the rules under the Late Enrollment section, and will be effective as described in the *Effective Date of Coverage* section.]

[When Coverage Ends for Dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents' [medical] coverage;
- You do not make the required contribution toward the cost of dependents' coverage. [See *Premium Contribution Provisions* for more information];
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for [Employees] [(other than exhaustion of your overall maximum lifetime benefit)];
- Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the [calendar month] following the [calendar month] when your dependent no longer meets the plan's definition of a dependent.
- [Your dependent has exhausted his or her lifetime maximum benefit under your medical plan;] or
- Your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer.
- [Your life insurance is being extended under this Plan as a permanently and totally disabled employee.]

[Coverage for dependents' may continue for a period after your death. Coverage for handicapped dependents may continue after your dependent reaches any limiting age. See *Continuation of Coverage* for more information.]

[In addition a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership. In that event, you should provide your Employer with a completed and signed Declaration of Termination of Domestic Partnership.].

[Premium Contribution Provisions

This plan requires you to make premium contribution payments through a payroll deduction with your employer. Your employer will forward your payment to **Aetna**. **Aetna** will not pay benefits under this Booklet-Certificate in the absence of payment of current premium contributions. Any payment denial is subject to the complaint and appeals process described in this Booklet-Certificate.

Missed Premium Contribution Payments

If you miss a premium contribution payment because you were temporarily absent from work or you have not worked enough hours to cover your payroll deduction, **Aetna** will allow you to make direct payment to **Aetna** to make your premium contributions current and keep your coverage in force.

To submit a missed premium contribution you must complete the Missed Premium Contribution Payment form and submit it to the Missed Premium Department at **Aetna.** You must also submit your entire missed premium contribution amount for all elected coverage. Partial payments will not be accepted.

Payment must be received by **Aetna** [within 30 – 60 days after the date of the paycheck from which the weekly deduction would have been made by your employer] [and within 30-60 days after the date of the paycheck from which the bi-weekly deduction would have been made by your employer]. If payment is not received within such time, benefits will not be payable for losses or expenses incurred during any period of time that premium was unpaid.

A missed premium contribution payment will not be accepted for any period after your employment terminates. Coverage under this plan ends immediately upon termination of employment.

Life Insurance

If you have missed a premium contribution payment and you die prior to remitting payment to **Aetna,** your beneficiary may make a payment on your behalf and keep the policy in force**. Aetna** will allow the beneficiary of your **Aetna** life insurance policy to make a missed premium contribution payment within 45 days of your death providing your coverage was in effect 31 days prior to your date of death. Payment must be made in full for all coverage elected by you.

Clerical Errors

Aetna will evaluate any claims of administrative or clerical error by **Aetna** or the policyholder and will make exceptions and correction for any errors identified.]

[FACILITY INDEMNITY PLAN]

[This Plan will pay the applicable Facility Indemnity benefit described below for each **hospital [treatment facility**] **[rehabilitation facility] [hospice facility] [skilled nursing facility] [convalescent facility] stay** of an insured person if:

(a) the **stay** is due to treatment of an **injury** or disease;

(b) it occurs while the insured person is insured for this Facility Indemnity coverage; and

(c) it is advised by a **physician**.]

[The Intensive Care Unit (ICU) is a section within a **hospital** which is operated solely for critically ill patients. It must provide: special supplies; equipment; and constant observation; and care by an **R.N.** or other highly trained **hospital** personnel.

It does not include any **hospital** facility maintained for the purpose of providing normal post-operative recovery treatment or services.]

[Facility Indemnity Benefit

This Plan will pay the benefits set forth below for each **stay**:]

[Facility Indemnity Benefit:]	[**Network Provider**] [**Limitations**]	[**Out-of-Network Provider**] [**Limitations**]
[Daily Benefit:		
Board & Room Daily Maximum	[$100]	[$100]
Maximum Number of Days	[15 days per confinement]	[15 days per confinement]
Intensive Care Unit Daily Maximum	[$100]	[$100]
Maximum Number of Days	[15 days per confinement]	[15 days per confinement]
Board & Room/Intensive Care Unit Daily Maximum	[$100]	[$100]
Maximum Number of Days	[15 days per confinement]	[15 days per confinement]
Calendar Year Maximum	[5 days]	[5 days]]
[Period of Confinement Benefit:		
Maximum Benefit	[$1,000 per period of confinement]	[$1,000 per period of confinement]
Calendar Year Maximum	[1 period of confinement]	[1 period of confinement]]

[This Plan will pay a Daily Benefit for each day of the **stay**. The Board and Room and Intensive Care Unit Daily Maximums and Calendar Year Number of Days Maximum are shown in your Summary of Coverage. [For confinements in the Intensive Care Unit of a **hospital**, the Intensive Care Unit Daily Maximum is an additional benefit to the Board & Room Daily Maximum Daily Maximum.]]

[This Plan will pay a benefit Per Period of Confinement. The Per Period of Confinement Maximum Benefit and Periods of Confinement Calendar Year Maximum are shown in your Summary of Coverage.]

[FACILITY INDEMNITY PLAN]

[This Plan will pay the applicable Facility Indemnity benefit described below for each **hospital [treatment facility**] **[rehabilitation facility] [hospice facility] [skilled nursing facility] [convalescent facility] stay** of an insured person if:

(a) the **stay** is due to treatment of an **injury** or disease;

(b) it occurs while the insured person is insured for this Facility Indemnity coverage; and

(c) it is advised by a **physician**.]

[The Intensive Care Unit (ICU) is a section within a **hospital** which is operated solely for critically ill patients. It must provide: special supplies; equipment; and constant observation and care by an **R.N.** or other highly trained **hospital** personnel.

It does not include any **hospital** facility maintained for the purpose of providing normal post-operative recovery treatment or services.]

[Facility Indemnity Benefit

This Plan will pay the benefits set forth below for each **stay**:]

[Facility Indemnity Benefit:]	[**Network Provider**] [**Limitations**]	[**Out-of-Network Provider**] [**Limitations**]
[Daily Benefit:		
Board & Room Daily Maximum	[$100-$1,000]	[$100-$1,000]
Maximum Number of Days	[15-100 days per confinement]	[15-100 days per confinement]
Intensive Care Unit Daily Maximum	[$100-$1,000]	[$100-$1,000]
Maximum Number of Days	[15-100 days per confinement]	[15-100 days per confinement]
Board & Room/Intensive Care Unit Daily Maximum	[$100-$1,000]	[$100-$1,000]
Maximum Number of Days	[15-100 days per confinement]	[15-100 days per confinement]
Calendar Year Maximum	[5-100 days]	[5-100 days]]
[Period of Confinement Benefit:		
Maximum Benefit	[$1,000-$10,000 per period of confinement]	[$1,000-$10,000 per period of confinement]
Calendar Year Maximum	[1-2 periods of confinement]	[1-2 periods of confinement]]

[This Plan will pay a Daily Benefit for each day of the **stay**. The Board and Room and Intensive Care Unit Daily Maximums and Calendar Year Number of Days Maximum are shown in your Summary of Coverage. [For confinements in the Intensive Care Unit of a **hospital**, the Intensive Care Unit Daily Maximum is an additional benefit to the Board & Room Daily Maximum Daily Maximum.]]

[This Plan will pay a benefit Per Period of Confinement. The Per Period of Confinement Maximum Benefit and Periods of Confinement Calendar Year Maximum are shown in your Summary of Coverage.]

[Glossary]

[Directory

A listing of all **network providers** serving the class of employees to which you belong. The policyholder will give you a copy of this **directory**. **Network provider** information is also available through **Aetna**'s on-line provider **directory**, [DocFind].]

[Network Provider

A health care provider who has contracted to furnish services or supplies; but only if the provider is, with **Aetna**'s consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.]

[Out-of-Network Provider

A health care provider who has not contracted with **Aetna** to furnish services or supplies.]

[Premium Contribution Provisions

This plan requires you to make premium contribution payments through a payroll deduction with your employer. Your employer will forward your payment to **Aetna**. **Aetna** will not pay benefits under this Booklet-Certificate in the absence of payment of current premium contributions. Any payment denial is subject to the complaint and appeals process described in this Booklet-Certificate.

Missed Premium Contribution Payments

If you miss a premium contribution payment because you were temporarily absent from work or you have not worked enough hours to cover your payroll deduction, **Aetna** will allow you to make direct payment to **Aetna** to make your premium contributions current and keep your coverage in force.

To submit a missed premium contribution you must complete the Missed Premium Contribution Payment form and submit it to the Missed Premium Department at **Aetna.** You must also submit your entire missed premium contribution amount for all elected coverage. Partial payments will not be accepted.

Payment must be received by **Aetna** [within 30 days after the date of the paycheck from which the weekly deduction would have been made by your employer] [and within 30 days after the date of the paycheck from which the bi-weekly deduction would have been made by your employer]. If payment is not received within such time, benefits will not be payable for losses or expenses incurred during any period of time that premium was unpaid.

A missed premium contribution payment will not be accepted for any period after your employment terminates. Coverage under this plan ends immediately upon termination of employment.

Clerical Errors
Aetna will evaluate any claims of administrative or clerical error by **Aetna** or the policyholder and will make exceptions and correction for any errors identified.]

[Premium Contribution Provisions

This plan requires you to make premium contribution payments through a payroll deduction with your employer. Your employer will forward your payment to **Aetna**. **Aetna** will not pay benefits under this Booklet-Certificate in the absence of payment of current premium contributions. Any payment denial is subject to the complaint and appeals process described in this Booklet-Certificate.

Missed Premium Contribution Payments

If you miss a premium contribution payment because you were temporarily absent from work or you have not worked enough hours to cover your payroll deduction, **Aetna** will allow you to make direct payment to **Aetna** to make your premium contributions current and keep your coverage in force.

To submit a missed premium contribution you must complete the Missed Premium Contribution Payment form and submit it to the Missed Premium Department at **Aetna.** You must also submit your entire missed premium contribution amount for all elected coverage. Partial payments will not be accepted.

Payment must be received by **Aetna** [within 30 – 60 days after the date of the paycheck from which the weekly deduction would have been made by your employer] [and within 30-60 days after the date of the paycheck from which the bi-weekly deduction would have been made by your employer]. If payment is not received within such time, benefits will not be payable for losses or expenses incurred during any period of time that premium was unpaid.

A missed premium contribution payment will not be accepted for any period after your employment terminates. Coverage under this plan ends immediately upon termination of employment.

Clerical Errors

Aetna will evaluate any claims of administrative or clerical error by **Aetna** or the policyholder and will make exceptions and correction for any errors identified.]

SERFF Tracking Number:	*AENX-125694181*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*39294*
Company Tracking Number:	*GH AR0033301F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2008 Business Alliance*		
Project Name/Number:	*2008 Business Alliance/GH AR0033301F01*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AENX-125694181*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*39294*
Company Tracking Number:	*GH AR0033301F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2008 Business Alliance*		
Project Name/Number:	*2008 Business Alliance/GH AR0033301F01*		

Supporting Document Schedules

Review Status:

Bypassed -Name: Application — Approved-Closed — 06/13/2008

Bypass Reason: Not appicable

Comments:

Review Status:

Bypassed -Name: Health - Actuarial Justification — Approved-Closed — 06/13/2008

Bypass Reason: not applicable

Comments:

Review Status:

Bypassed -Name: Outline of Coverage — Approved-Closed — 06/13/2008

Bypass Reason: Not applicable

Comments:

Review Status:

Satisfied -Name: Certification/Notice — Approved-Closed — 06/13/2008

Comments:

Attachments:

AR - NAIC TRANSMITTAL DOC.PDF

AR - NAIC FORM FILING ATTACHMENT.PDF

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	**Prepared for the State of**	Arkansas

2.	**Department Use Only**
	State Tracking ID

3.	**Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**	**State #**
Aetna Life Insurance Company 151 Farmington Avenue Hartford CT 06156		CT		001	60054	06-6033492	

4.	**Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**
John Ciesielski 151 Farmington Avenue, Mail Stop RW61 Hartford CT 06156		860-279-1282	860-952-2069	CiesielskiJW@Aetna.com

5.	**Requested Filing Mode**	☐ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	GH AR0033301F01	
7.	☐ **New Submission** ☐ **Resubmission**	Previous file # _____	
8.	**Market**	☐ Individual ☐ Franchise	
		Group	☐ Small ☐ Large ☒ Small and Large ☒ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	**Type of Insurance**	H21 Health - Other	
10.	**Product Coding Matrix Filing Code**	H21.000 Health - Other	
11.	**Submitted Documents**	☐ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☐ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☐ **RATES** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☐ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other: _____	

12.	**Filing Submission Date**	
13.	**Filing Fee (If required)**	Amount _____ Check Date _____ Retaliatory ☐ Yes ☐ No Check Number _____
14.	**Date of Domiciliary Approval**	
15.	**Filing Description:**	

The purpose of this submission is to expand benefit ranges and add new benefit features to our medical plans in order to enhance plan design flexibility for our policyholders.

In addition:
In response to a given policyholder's needs, a plan may be written as an accident only medical plan. The terms "illness" and/or "disease" will be deleted accordingly from the plan documents if a policyholder's plan is an accident only medical plan.

In response to a given policyholder's needs, a plan may be written as an outpatient only medical plan. References to inpatient facility expenses will be deleted accordingly from the plan documents if a policyholder's plan is an outpatient only medical plan. Outpatient only medical plans will be offered in conjunction with a hospital (or hospital/inpatient facility) confinement indemnity plan to policyholders.
The hospital (or hospital/inpatient facility) confinement indemnity plans may be network based.

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name John Ciesielski Title Product and Regulatory Affairs Manager

Signature _____ Date _____

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	GH AR0033301F01
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	What The Plan Covers	GR-9N 14-005 02	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
02	Physician Services	GR-9N 14-025 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
03	Exclusions	GR-9N 28-015 05	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
04	Calendar Year Deductibles	GR-9N S-14-05 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
05	[Calendar Year] [Monthly] Maximum Benefits	GR-9N S-14-10 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
06	Treatment of Injuries Relating To An Accident	GR-9N S-14-20 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
07	Routine Preventative Care Expenses	GR-9N S-14-25 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
08	Physician Expenses	GR-9N S-14-30 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
09	Hospital Expenses/Facility Expenses	GR-9N S-14-35 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
10	Coverage for Emergency Medical Conditions	GR-9N S-14-40 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
11	Alternatives to Hospital Stays	GR-9N S-14-45 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	GH AR0033301F01
This filing corresponds to rate filing company tracking number	

	Document Name / Description	Form Number		Replaced Form Number / Previous State Filing Number
12	Other Covered Health Care Expenses	GR-9N S-14-50 03	☒ Initial ☐ Revised ☐ Other _____	
13	Specialized Care	GR-9N S-14-55 03	☒ Initial ☐ Revised ☐ Other _____	
14	Treatment of Alcoholism, Drug Abuse	GR-9N S-14-60 03	☒ Initial ☐ Revised ☐ Other _____	
15	Oral and Maxillofacial Treatment	GR-9N S-14-65 03	☒ Initial ☐ Revised ☐ Other _____	
16	Supplemental Expense Benefits	GR-9N S-14-70 03	☒ Initial ☐ Revised ☐ Other _____	
17	Calendar Year Deductibles	GR-9N S-15-05 03	☒ Initial ☐ Revised ☐ Other _____	
18	Calendar Year and Monthly Maximum Benefits	GR-9N S-15-10 03	☒ Initial ☐ Revised ☐ Other _____	
19	Lifetime Maximum Benefits	GR-9N S-15-15 03	☒ Initial ☐ Revised ☐ Other _____	
20	Treatment of Injuries Relating To An Accident Benefit	GR-9N S-15-20 03	☒ Initial ☐ Revised ☐ Other _____	
21	Routine Preventative Care Expenses	GR-9N S-15-25 03	☒ Initial ☐ Revised ☐ Other _____	
22	Physician Expenses	GR-9N S-15-30 03	☒ Initial ☐ Revised ☐ Other _____	

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	GH AR0033301F01
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
23	Hospital Expenses/Facility Expenses	GR-9N S-15-35 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
24	Coverage for Emergency Medical Conditions	GR-9N S-15-40 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
25	Alternatives to Hospital Stays	GR-9N S-15-45 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
26	Other Covered Health Care Expenses	GR-9N S-15-50 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
27	Specialized Care	GR-9N S-15-55 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
28	Treatment of Alcoholism, Drug Abuse	GR-9N S-15-60 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
29	Oral and Maxillofacila Treatment	GR-9N S-15-65 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
30	Supplemental Expense Benefits	GR-9N S-15-70 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
31	When Coverage Ends for Employees	GR-9N 30-005 03	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
32	When Coverage Ends for Dependents	GR-9N 30-015 04	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
33	Premium Contribution Provisions	GR-9N 30-020 01	☒ **Initial** ☐ **Revised** ☐ **Other** _____	

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	GH AR0033301F01
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
34	Facility Indemnity Plan (Without Ranges)	GR-96173 50-1b	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
35	Facility Indemnity Plan (With Ranges)	GR-96173 50-1b	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
36	Glossary	GR-96173 80-5d	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
37	Premium Contribution Provisions (Without Ranges)	GR-96173 90	☒ **Initial** ☐ **Revised** ☐ **Other** _____	
38	Premium Contribution Provisions (With Ranges)	GR-96173 90	☒ **Initial** ☐ **Revised** ☐ **Other** _____	